Volume 10

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE JOSEPH C. SPERO, MAGISTRATE JUDGE

DAVID AND NATASHA WIT, et al.,	)	
	)	
Plaintiffs,	)	
	)	
VS.	)	**No. C 14-2346 JCS**
	)	
UNITED BEHAVIORAL HEALTH,	)	
	)	
Defendant.	)	
	)	San Francisco, California
		Wednesday, November 1, 2017

TRANSCRIPT OF PROCEEDINGS

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I N D E X

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P R O C E E D I N G S

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THE CLERK: Okay. We're calling Case Number C 14-2346, witness/Alexander versus UBH. Everybody here's, so...

THE COURT: All right. Time for closing arguments. Let's proceed.

MR. GOELMAN: Good morning, Your Honor.

THE COURT: Good morning.

MR. GOELMAN: I believe I speak for both parties when I say thank you for the candy.

(Laughter)

THE COURT: Oh, I should have mentioned it's required that you eat the candy because I'm not bringing that back into chambers.

(Laughter)

THE COURT: It's probably not appropriate in an healthcare case, but....

Okay. Go ahead.

MR. GOELMAN: Your Honor, I'd like to reserve 20 minutes for rebuttal with the Court's permission.

THE COURT: Okay. So what are we clocking him at?

THE CLERK: So --

THE COURT: Let's put down an hour and hopefully that

will be enough --

MR. GOELMAN: It should be.

THE COURT: -- but reserve 20 minutes of that hour for rebuttal. We'll let you know when you're getting close to the 20 minutes.

MR. GOELMAN: Oh. The 20 minutes comes out of the hour?

THE COURT: Oh, yes.

MR. GOELMAN: Okay.

THE COURT: Well, I don't know. What do you think?

MR. GOELMAN: I think I'll be done within an hour, the principal closing.

THE COURT: Fine.

MR. GOELMAN: And then I'd like at least to have the option of coming back for 20 minutes after the defense closing.

THE COURT: Okay. Well, try to make it as concise as you can, please.

MR. GOELMAN: I will. I will.

CLOSING ARGUMENT

MR. GOELMAN: UBH chose to administer thousands of discrete ERISA plans. Each of those plans has its own plan document, its own collection of beneficiaries. In order to ease the burden of administering so many plans and because all of the plans required as one condition of coverage that the prescribed treatment be consistent with generally accepted

standards of care, UBH developed Level of Care Guidelines that purported to embody those standards so that it could use those guidelines to make coverage determinations.

UBH chose to administer its plans in this manner, but that didn't change the fact that it was legally required to interpret each of those plans according to its terms and exercise its discretion solely for the benefit of its beneficiaries. The evidence shows it did not do that.

The evidence shows that each time there was a decision to be made about how to draft a guideline, UBH's own financial interests trumped the interests of plan beneficiaries. It's no accident that UBH ended up with guidelines that were and are pervasively, systemically, and improperly more restrictive than the generally accepted standards and that they used those guidelines to deny members' claims.

The Court has provided the parties with a list of issues to be addressed in this case and has asked the parties to address whether and why particular provisions of the guidelines are consistent with the generally accepted standards and to point to particular evidence in the record that supports our position. We will do so both today and in more detail in posttrial briefing but before I turn to that, I want to address one issue, witness credibility, because not all testimony is created equal. Plaintiffs' experts gave testimony that should be credited in full. Defendant's witnesses did not.

First, demeanor. Witnesses' demeanor and behavior on the stand matter. The Court had the opportunity to sit closer than anyone else in this courtroom as the witnesses testified. The Court had the opportunity to ask its own questions of these witnesses. So the Court no doubt already has its own opinions about their credibility.

Here's why the Court should credit the testimony and opinions of the plaintiffs' experts and accept their opinion that UBH's Level of Care Guidelines fell far below the generally accepted standards.

First, the Court heard from Dr. Mark Fishman, one of the leading architects of the ASAM criteria, which every witness asked has admitted is generally accepted standards for substance use disorder and is by far the most widely used, broadly accepted iteration of those standards.

The Court also heard from Dr. Plakun, a long-time practitioner, former faculty member at the Harvard Medical School, someone who has written a number of peer-reviewed articles on issues directly relevant to this case, and someone who runs one of the most highly regarded residential treatment facilities for mental health disorders in the country.

Both of these men took the witness stand and walked the Court through chapter and verse their problems with UBH's guidelines and why they both concluded that they fell far short of generally accepted standards.

The Court should credit their testimony not just because they are leading experts in their respective fields, but because the Court had the opportunity to hear and watch them testify, to judge their seriousness and credibility by their demeanor, and their testimony had all the hallmarks of authenticity and credibility. They testified the same on direct examination and cross-examination. Their testimony, while internally consistent, was not identical with each other.

The opinions offered by all the experts in this case are not based on immutable laws of physics or mathematics, so you'd expect there to be some daylight even between one party's experts, and there was some daylight between Drs. Fishman and Plakun. Defendant's experts, however, were in lockstep, often verbatim. That's a sign of careful coaching, not authenticity.

Dr. Fishman and Dr. Plakun were unrehearsed and they both called the balls and strikes the way they saw them, including endorsing certain parts of the guidelines when they felt that that was warranted.

You may not agree with their opinions, although you should, but there can be no doubt that these two men believed what they told you and that their opinions were based on vast experience and careful thought and consideration.

Dr. Simpatico. The difference between Dr. Simpatico and the plaintiffs' expert witnesses could not be starker. Dr. Simpatico testified over two days after sitting in court

and watching for part of the trial, so he was definitely prepared. He gave testimony that in style, diction, and delivery was rehearsed and almost preprogrammed, but what really destroyed Dr. Simpatico's credibility wasn't his delivery. It was the substance of his testimony. It was his shifting answers, particularly when he was answering difficult questions from the Court instead of scripted ones from his own lawyer. It was his insistence that words on a page do not mean what they say.

A standard jury instruction, Your Honor, is that jurors if they don't find a particular witness credible, they can reject his or her testimony in whole or in part. Plaintiffs submit that Dr. Simpatico was so profoundly noncredible that the Court should disregard his testimony in its entirety.

Plaintiffs after listening to and watching Dr. Simpatico's testimony over two days made the unusual and, for trial lawyers, exceedingly difficult decision to waive cross-examination. We did so because we couldn't imagine Dr. Simpatico being more thoroughly discredited than he already was. His testimony should simply not count as evidence. His opinion, to the extent that he genuinely has one, should carry no weight with the Court and should carry no weight when the Court goes through the guideline provisions and decides which party's experts are more persuasive.

UBH's nonretained experts, on the other hand, were not

utterly without credibility but they were certainly not independent, and none of them were able to offer any explanation as to why their reading of the guidelines comported with the actual text of the guidelines. Instead, over and over they told the Court that the words don't mean what they say.

Now, I want to turn to the issues that the Court has asked the parties to focus on. Some of them are easy, and I want to tick through those first.

The Court asked: Does ERISA apply? The answer is yes. The parties stipulated that every class member's plan was governed by ERISA, and that stipulation is in evidence as Exhibit 896.

Was UBH acting as a fiduciary? The answer again is yes. There's no question that in its role of administering these benefits, UBH was interpreting these plans. You see that again and again in the plan language itself. And the act of writing and amending the guidelines was the method by which UBH decided to interpret the plans. Indeed, the guidelines explicitly state that they are designed to standardize UBH's plan interpretation.

The next question: Did UBH use the guidelines in whole or in part to make coverage determinations?

THE COURT: So I missed that last part. So the guidelines themselves say what?

MR. GOELMAN: That they are designed to standardize

UBH's plan interpretation.

THE COURT: And that's in the texts of the Level of Care Guidelines?

MR. GOELMAN: I believe that is in the introduction, "standardize the coverage determinations."

Next question: Did UBH use the guidelines in whole or in part to make coverage determinations? Indisputably it did. Every denial cited a guideline, and this is set forth in plaintiffs' summary Exhibit 894, which Ms. Duh testified about.

Not only that, UBH's employees testified consistently that application of the guidelines was mandatory, and I refer the Court just to one example of this testimony. It was from Dr. Triana at page 709 of the transcript, lines 10 to 12 (reading):

"QUESTION: It's true UBH cannot make a clinical noncoverage determination without citing a guideline; is that correct?

"ANSWER: That is correct."

728:18 to 729:2 (reading):

"QUESTION: And you agree that when UBH issues an adverse benefit determination for lack of medical necessity, it means that a peer reviewer concluded that the case did not meet the criteria in UBH's Level of Care Guidelines?

"ANSWER: Yes.

"QUESTION: And when UBH makes a clinical coverage

determination to deny benefits, it means that a peer reviewer concluded that the case did not meet the criteria and the applicable CDGs; is that also correct?

"ANSWER: Correct."

Next question. Did the CDGs incorporate the Level of Care Guidelines? The answer again is yes. The parties have entered a stipulation. It's marked as Exhibit 880 and it's in evidence. It sets forth the evidence that over the years of the class, the Level of Care Guidelines were incorporated into the CDGs.

In 2017, the CDGs contained a hyperlink to the Level of Care Guidelines. From 2014 to 2016 --

THE COURT: So in 2017 all of the CDGs contained a hyperlink to the complete Level of Care Guidelines?

MR. GOELMAN: All of the CDGs contain a hyperlink to at least the common criteria of the Level of Care Guidelines, all of the CDGs at issue in this case.

THE COURT: Contain a hyperlink to the common criteria?

MR. GOELMAN: I believe that's correct. And then once you're in the common criteria, you're in the Level of Care Guidelines.

THE COURT: Well, you're in the common criteria for the Level of Care Guidelines.

MR. GOELMAN: Correct. I think if you go down, you

can see the rest of the guidelines. You don't have to go to another link.

THE COURT: Yes. I see. It's a link to the entirety of the guidelines, but it starts at the common criteria; is that what you're saying?

MR. GOELMAN: I believe that's accurate.

THE COURT: Okay. Thank you.

And your position is that a reviewer reviewing the CDGs for 2017, for example --

MR. GOELMAN: Uh-huh.

THE COURT: -- because there is a link must also review whether or not coverage of the particular treatment is appropriate under the Level of Care Guidelines? Must do that?

MR. GOELMAN: I think that --

THE COURT: I'm wondering what you mean by "incorporated."

MR. GOELMAN: Well, I think that the individual reviewers use the guidelines in every case, and there's evidence of that.

I think that --

THE COURT: Individual reviewers use what in every case?

MR. GOELMAN: Guidelines, whether it's CDGs --

THE COURT: Some guidelines, yes.

MR. GOELMAN: Right.

THE COURT: I understand.

MR. GOELMAN: And I think that --

THE COURT: We're distinguishing between CDGs and Level of Care Guidelines.

MR. GOELMAN: I think that the fact -- well, when the Court asks must every reviewer click on that hyperlink every time, I don't think there's any evidence in the case one way or another about that; but the presence of that hyperlink in the CDG incorporates the terms of the Level of Care Guidelines.

THE COURT: "Incorporates the terms." What does it say when it says the hyperlink?

MR. GOELMAN: Your Honor, the CDGs contain no level of care criteria except for the link to the level of care criteria. So if a --

THE COURT: The CDGs don't say anything about whether or not you're allowed to have this in a residential setting?

MR. GOELMAN: I don't believe that they set forth the criteria to choose a level of care. I think they deal with the disorder specific.

THE COURT: Right. Disorder specific.

MR. GOELMAN: There's a section in the CDGs that says "Level of Care Guidelines" --

THE COURT: Yeah.

MR. GOELMAN: -- but then there's no substance in there. All there is is the hyperlink.

THE COURT: What does it say?

MR. GOELMAN: It says -- Optum has the computer designation for the hyperlink, "Optum/OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at," and then it has a hyperlink. And then it says (reading):

"The Level of Care Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support member's recovery, resiliency, and well-being."

THE COURT: Okay.

MR. GOELMAN: So if you're a reviewer and you're in the CDG and you want to figure out what Level of Care Guidelines should be applied, you go to the link. That's for 2017.

From 2014 to 2016, the Level of Care Guidelines were literally copied and pasted into the CDGs.

THE COURT: In their entirety?

MR. GOELMAN: I was afraid you were going to ask that.

THE COURT: Yeah, of course.

MR. GOELMAN: The answer is yes.

THE COURT: So each CDG copied and pasted the entirety of the Level of Care Guidelines for that year? These Level of Care Guidelines are very long.

MR. GOELMAN: Can I have my co-counsel answer this

question?

THE COURT: Sure.

MS. REYNOLDS: Okay. Yes, Your Honor, as reflected in the stipulation, the common criteria are copied verbatim in their entirety in each of the guidelines where the column G has a checkmark, and the --

THE COURT: Each of the guidelines where column G has a checkmark. Is that all of them?

MS. REYNOLDS: It is -- let me look. I mean, it's not -- it's not every single one, but the ones that have a checkmark in that column have copied the language verbatim.

THE COURT: Yeah, I understand that, but the problem here is we're judging all 216 CDGs, or whatever it is. So most of them? Some of them?

MS. REYNOLDS: Most of them, Your Honor.

THE COURT: Okay. And the others didn't?

MS. REYNOLDS: In years before 2014 --

THE COURT: 2014 to 2016 is all we're talking about.

MS. REYNOLDS: Right.

THE COURT: 2014 to 2016 most of them but not all of them?

MS. REYNOLDS: Right, the vast majority.

THE COURT: And what about the rest?

MS. REYNOLDS: The other ones use the same format as the earlier years where there's incorporation by reference --

THE COURT: Okay.

MS. REYNOLDS: -- according to other language.

THE COURT: And so the 2011 to 2014 -- '13, what's the guidelines?

MS. REYNOLDS: Right. So 2011 to 2013 there are references to the Level of Care Guidelines and there are statements to the effect, for example, that UBH maintains that coverage must be consistent with its Level of Care Guidelines, that coverage is excluded if it's not consistent with the Level of Care Guidelines. And then, as we saw in 2017, there aren't other level of care criteria in those guidelines necessarily.

THE COURT: So every one from 2011 to 2013 says, either affirmatively or negatively, you have to comply with the Level of Care Guidelines?

MS. REYNOLDS: There are -- there are some on the list where the only incorporation is a parenthetical citation to the Level of Care Guidelines, and those are indicated in column D. And so the Court can see on the chart which ones have only a checkmark in that column.

More often and, you know, the vast majority of the time there is language from column A, B, and/or C, often two of the three.

THE COURT: What are those saying?

MS. REYNOLDS: So A is a citation to an exclusion of coverage --

THE COURT: Right.

MS. REYNOLDS: -- when the services are not consistent with the Level of Care Guidelines.

THE COURT: Right.

MS. REYNOLDS: B is the statement, the affirmative statement, that UBH maintains that treatment should be consistent with its Level of Care Guidelines.

THE COURT: Uh-huh.

MS. REYNOLDS: And C is a reference to UBH maintaining clinical protocols that include the Level of Care Guidelines which describe scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding treatment that are available upon request. And that's generally coupled with one or more of the other types of language.

THE COURT: Okay.

Okay. Got it. Thank you.

MS. REYNOLDS: Okay.

MR. GOELMAN: The next question concerns exhaustion. The question is: Did the members of the class exhaust their administrative remedies? And, again, the answer is yes. The evidence is that UBH on appeal applied the same flawed guidelines, so appeal was and would have been futile.

I'm going to turn to the state mandates and the question that the Court had about whether or not the guidelines violated

the state mandates. The answer again is yes. That's why UBH lied to the State of Connecticut. That's why it told the Connecticut Department of Insurance that its guidelines contained criteria for all the ASAM levels for residential treatment even while acknowledging the precise opposite to its own consultant to whom it told a different untruth, that it didn't need criteria for low-intensity residential treatment because the plans it administered didn't cover it.

It wasn't just Connecticut. Illinois mandated the use of ASAM beginning in 2011. A year later, Jerry Niewenhous sent this e-mail, which is in evidence at Exhibit 353, page 002. First there's an e-mail from Jeremy Hodess to him. It says in part (reading):

> "We have continued to operate here in St. Louis as though we do not need to cite ASAM in our coverage determinations for treatment of SUDS on commercial members in Illinois. Based on previous advice, we were operating as though our LOCGs/CDGs are generally 'in accordance' with ASAM criteria."

Mr. Niewenhous's response is above (reading):

> "Jeremy, you're correct, operating as though our guidelines are in accordance with ASAM's criteria."

The problem is they're not in accordance with ASAM's criteria. UBH's guidelines are very much not in accordance with ASAM, and UBH knew that at the time.

It wasn't just Connecticut and Illinois.

THE COURT: How long did the situation obtain in either of those states? So in Connecticut, when were they required to apply ASAM in Connecticut?

MR. GOELMAN: I think that the Connecticut statute was enforce in 2014 -- 2013. Illinois was even before the class started.

THE COURT: And how long before they applied ASAM in Connecticut? They're still not applying ASAM in Connecticut?

MR. GOELMAN: Correct.

THE COURT: And in Illinois, how long before they complied with the 2011 law to apply ASAM?

MR. GOELMAN: 2016, Your Honor.

THE COURT: Okay. Go ahead.

MR. GOELMAN: Texas has required application of its own criteria for SUD placement since before the class period started, and Mr. Niewenhous testified at trial that UBH used the Texas criteria since before the class period. The problem is that that's not true either, and Exhibit 493 is an e-mail again with Mr. Niewenhous part of the chain at 0002. It talks about the TCADA guidelines which are the Texas State regulations (reading):

"Question from Houston about whether the TCADA guidelines apply or the CDGs. Former required by State reg, latter thought to apply because of Parity. Houston

has been using the CDGs. Meeting with Tom Hamlin, Adam, and Kevin later this week."

That's from May 2015. And the Court heard testimony from Dr. Fishman who voiced the opinion that the UBH guidelines do not comply with the Texas regulations for placement of substance use disorder patients.

THE COURT: And Texas permits the use of alternative?

MR. GOELMAN: Texas has its own regulations.

THE COURT: You're allowed to apply your own guidelines if they're consistent with the Texas regulation, or do you have to apply the Texas regulation?

MR. GOELMAN: If they're consistent with the Texas regulation, you may apply your own. The question is whether or not UBH's were consistent.

THE COURT: Got it.

MR. GOELMAN: It wasn't just Connecticut, Illinois, and Texas; it's also Rhode Island, which has required ASAM since 2015. But just yesterday, October 31st, 2017, Mr. Niewenhous conceded that UBH -- and this is at 1809, lines 11 to 13 of the transcript -- has never adopted ASAM criteria in Rhode Island for commercial plans.

Oh, I'm told that Texas is mandatory. You actually have to use TCADA. You cannot use your own guidelines even if they are consistent or you think they're consistent with the Texas regs.

So those questions are relatively easy, but I don't want to pretend that all the questions --

THE COURT: So what is -- I guess I don't understand about Texas. There's an e-mail chain where somebody says Houston is not using this. What does "Houston" mean?

MR. GOELMAN: I think "Houston" is the CAC that is responsible for plans for members who live in Texas.

THE COURT: Okay.

MR. GOELMAN: If all the questions in this trial were easy, the parties would not have spent the last three weeks boring everyone in the courtroom parsing language from the various iterations of the guidelines.

So the big question in this case is: Are the guidelines at issue inconsistent with the class members' plans? And this question and answer has several subparts; some easy, one is not.

One easy one is: Did the plans require compliance with the generally accepted standards as one condition of coverage? That's an easy yes. The plans contain language using that or virtually identical language and make clear that UBH cannot approve coverage without finding that the services meet that standard. That is set forth in plaintiffs' summary Exhibit 892, which Ms. Duh testified about earlier in the case.

Another question: Did UBH reasonably interpret that requirement when it wrote, amended, and applied the guidelines?

Now, this subquestion itself has several parts, some easier than others.

First, what standard do we use in evaluating that question? I note for Claim 2 it's abuse of discretion. During the pretrial conference, the Court made it clear that it believes that it is also the appropriate standard for Claim 1. We have reasons that we think the Court should use a lower standard for the first claim, which we're happy to put in our posttrial briefs but don't want to take the time to argue it here today, so we will assume that we're operating under the abuse of discretion standard for both claims but plaintiffs prevail regardless.

First, the abuse of discretion asks whether UBH's interpretation of the plan was reasonable. It was not. No reasonable and faithful fiduciary would interpret the generally accepted standards the way that UBH did with the overemphasis on acuity and underemphasis on chronicity and comorbidity and with the distortions of CMS definitions of "improvement," "custodial care," and "active treatment."

Then we get to the hard part or the big question: Did the guidelines at issue violate generally accepted standards? And I said it was hard but not because it's a close call. It's not. It's hard because it's complicated and the Court will need to make findings on why the guidelines are flawed or not flawed in each year, and there are various guidelines that some

of the language changes from year to year.

But the parties agree on one thing in this case, Your Honor; that the changes to the guidelines between 2011 and 2017 did not change the fundamental nature and did not bring them into or take them out of compliance with the generally accepted standards.

So where does the Court look to see what the real genuinely accepted standards are and were?

THE COURT: So let me just ask you a question about the latter. That seems to me to be an irrelevancy because they agree that it doesn't take them out of compliance because they think every year is in compliance with generally accepted standards of care.

But if you told them, "Well, I've decided that 2014, which has the 'why now' factors, is not inconsistent with generally accepted standards of care," they'd look to 2017 and they'd say, "Well, we don't have that anymore."

So you have to go through every one. You can't just say that the fact that for varying -- for different reasons, based on our own assumptions about where we end up, we're going to say that there's no change in whether or not they comply with the generally accepted standard of care. It's too simplistic.

MR. GOELMAN: Okay.

THE COURT: The reason I say that is because it affects remedy because if I say, for example, that the 2014

violated the generally accepted standards of care but the 2017 doesn't, I'm not sure what the remedy is, and it would be different if I thought both of them were.

MR. GOELMAN: Fair enough. I'm sure both parties' fallback position will be that certain guidelines do and certain don't.

THE COURT: Right.

MR. GOELMAN: I want to talk about what the sources of generally accepted standards are because I don't think there's much of a dispute about a lot of that.

Plaintiffs have always maintained while there's no book that's entitled "The Generally Accepted Standards of Care for X," that there are and were generally accepted standards of care reflected in various authoritative government and professional sources. The evidence has proved that out. Witnesses for both sides have identified some of these sources: CMS guidelines, ASAM, LOCUS, CALOCUS, and others.

In 2015, UBH started to include in their guidelines cites to some of these and other sources; and you see some of the sources cited repeatedly, including ASAM, including CMS. If this was a law school source cite quiz, the Table of Authorities would say ibid for CMS.

But as the Court has seen, the citations in UBH's guidelines can't be trusted to support the propositions that they are cited for. UBH repeatedly added or deleted critical

language that changed the meaning of the original source and this, Your Honor, was not the product of carelessness or mistake. If it had been, you'd expect to see mistakes in both directions. Here, all the differences militate in one direction, restricting the care that members' plans promise them.

I want to just point the Court to a couple examples of this. The first one involves the definition of "reasonable expectation of improvement." This is the 2016 Level of Care Guideline 1.8, and there has been a lot of testimony about this in this trial. It is side by side with the CMS definition of "reasonable expectation of improvement."

Can you turn to the next slide, please. And then the next one again.

Okay. So both of these documents talk about "improvement in this context," and they have similar wording about "in this context is measured by comparing the effect of continuing treatment versus discontinuing" it in CMS; and in the UBH version "in this context is measured by weighing the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if the current level of care ends."

But -- and you go to the next -- UBH's version has dramatically changed the context that is relevant to the interpretation of "improvement." On the CMS side it says

(reading):

"For many other psychiatric patients, particularly those with long-term chronic conditions, control of symptoms and maintenance at a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement."

UBH, on the other hand, writes that there's a reasonable expectation that services will improve the member's presenting problems within a reasonable period of time. And then in 1.8.1 (reading):

"Improvement of the member's condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in the level of care."

So "in this context," it is modifying the stem clause of 1.8, "the reasonable expectation of services will improve the member's presenting problems within a reasonable period of time."

Go to the next one, please.

So on CMS you have reference to "long-term chronic conditions" and on the UBH side you have "presenting problems and acute signs and symptoms."

Move on to the next one, please.

And here in green is important language in the CMS definition that has been entirely omitted from UBH's definition

of "improvement" (reading):

"The treatment must at a minimum be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning."

If you go down again, and then one more.

So this is another big difference. The CMS side repeatedly refers to "maintaining the present level of functioning," and there is nothing at all on the United side that takes into account maintenance of function.

Is that the last one for here?

Okay. And the evidence is that UBH knows how to faithfully borrow from the CMS guidelines when it wants to. So now I want to direct the Court to a side-by-side comparison of the same CMS excerpt but instead of the commercial plans, this is what UBH says about reasonable expectation of improvement on the Medicare side. It's far more similar to the CMS definition than the commercial side.

Can you go down, please. Again.

Okay. So, again, "in this context" appears both in the CMS version and in the UBH version; but here, in the UBH version, "in this context" modifies "services that are for the purposes of diagnostic study or reasonably expected to improve the member's condition." Same language as on the CMS side.

And in this version that UBH uses, it talks about

"long-term or chronic conditions, control of symptoms, and maintenance of functioning," all part of the definition of "improvement."

THE COURT: Well, the "context" language argument doesn't work because the context in the CMS is the first paragraph and most of the second paragraph, which includes the reference to "prevention of deterioration, maintenance of function"; whereas, in the Medicare plan for UBH, "in this context" doesn't refer to that.

MR. GOELMAN: That's true, although "in this context" --

THE COURT: I mean, they did add later on more references to maintaining the patient's level of function.

MR. GOELMAN: Right. And "improvement in this context" on the Medicare side for UBH modifies at least the verbatim same sentence from the CMS side as opposed to what they created in 1.8. Right here it says "Services are for the purpose..."

THE COURT: One of the same sentences?

MR. GOELMAN: Right.

THE COURT: Yours is not quite that different. If you want to just talk about the first sentence, talking about 1.8, if it had "reasonable expectations of improving or improvement," it would have added something but it's not that different.

MR. GOELMAN: That's true, they're not as different, although in 1.8 it still says "presenting problems"; whereas, in the Medicare, it says "expected to improve the member's condition."

THE COURT: Okay.

MR. GOELMAN: But, you know, maybe it was inadvertent. Maybe they just messed up when they were borrowing from CMS for their commercial plans, but that's not what the evidence shows.

So let's turn to 307, which is the minutes of the July 1st, 2000, Coverage Determination Committee, second page of this exhibit.

This is something -- I'm sorry. It's from July 2010. I thought I said that. Oh. I said "2000." Thanks. Okay.

(reading)

"Add clarification" -- this is something that Jerry Niewenhous is supposed to do -- "Add clarification that reasonable expectation of improvement in a patient's condition is improvement in the patient's acute" -- underlined -- "condition."

Now let's turn to 10, Exhibit 10-0003. That's the Custodial Care and Inpatient Services CDG as it was modified in August of 2010, so one month after Mr. Niewenhous received this direction from the committee, and it indeed contains the language that he was instructed to put in there (reading):

"Improvement of the patient's condition is indicated

by the reduction or control of the acute symptoms that necessitated hospitalization or residential treatment in an acute or RTC."

But it doesn't stop with the CDG. The acute centric definition of "improvement" metastasizes through the Level of Care Guidelines as well, and the Court can see this in the 2012 version of the common criteria (reading):

"Improvement of the member's condition is indicated by the reduction or control of the acute symptoms that necessitated treatment in a level of care."

And you can even trace through contemporaneous documentary evidence of how this got from the CDG into the LOCG. That is at Exhibit 335-0007 (reading):

"Considerations of the substantial changes to the clinical guidelines from the 2011 edition to the 2012 edition" -- and it says there in black and white -- "added the indicator of 'improvement' from the Custodial Care CDG to the common criteria. 'Improvement of the member's condition as indicated by the reduction or control of the acute symptoms that necessitated treatment in a level of care.'"

So the way that CMS treats "reasonable expectation of improvement" is consistent with the generally accepted standards. UBH's requirement of "improvement within a reasonable period of time" is not. Both Dr. Fishman and

Dr. Plakun testified that this was inconsistent with generally accepted standards, that it reflected a ticking-clock approach that was monitoring a patient's progress.

Now, monitoring a patient's progress is not a bad thing in and of itself but that here, where coverage can be terminated if and when the patient wasn't getting better within the time period that UBH wanted, that violated the generally accepted standards of care.

What is UBH's response? Well, it's to pretend, for one thing, that its definition of "improvement" was much broader and more generous than it actually is and that it includes prevention of deterioration and maintenance of function and that the, quote, "within a reasonable period of time" was essentially surplusage. Again, this is belied by the contemporaneous documentary evidence.

I refer the Court now to Exhibit 360 -- can you go to the first page first, please -- an e-mail chain from January 2013 -- and now to pages 3 and 4 -- e-mail chain between Mr. Haberman and, again, Jerry Niewenhous. And the bottom portion that is highlighted here (reading):

> "Improvement in this context is measured by weighing the effectiveness of treatment and the current risk that the member's condition is likely to deteriorate or relapse if treatment in the current level of care were to be discontinued."

And then the question --

THE COURT: Why isn't that CMS, "... member's condition will deteriorate if the current level of care is discontinued"?

MR. GOELMAN: I think that actually is CMS. I think that it was... That is CMS. The dialogue here is the way that it is reflected in the Level of Care Guidelines, which I think it was Mr. Haberman said was troubling to him. Here's what he said, he said (reading):

"The sentence that I bolded below, it has reached more relevancy as a father of one of our member," quote the bolden sentence, "while talking about his son's case to one of our care advocates. His son's case is similar to many others where you have a child who is clearly dangerous or unresponsive to treatment. We can further easily assume that the member would deteriorate or relapse if treatment at the current level were discontinued. So the question is how you legitimately ABD," which is a denial, "such a case by calling it custodial, which is what the father was saying. My answer, which is implied in the paragraph, is that we always assume that services will improve the person's ability to function in the community and that there must be a reasonable expectation that this can occur within a reasonable period of time. The person's inability to improvement within a reasonable

period of time trumps the issue of whether they would deteriorate if discharged."

THE COURT: So what are you saying?

MR. GOELMAN: I'm saying this reflects UBH's approach that if you cannot improve or if you don't have a demonstrated track record of improvement within whatever they determine a reasonable period of time to be, that becomes more important -- the word "trumps" -- than the deterioration that would happen if they were discharged from that level of care.

THE COURT: That's what? That's how they're applying the language? I mean, the question is with the language.

MR. GOELMAN: That --

THE COURT: Are you saying that's what the language means?

MR. GOELMAN: Yeah. I'm saying that that is what they intended when they adopted the language.

THE COURT: Okay.

MR. GOELMAN: The defendant argues the different points in this case -- has argued -- that you can string adjectives together and that eliminates conflicts between the adjectives. So you have some of their experts talking about standards like the least restrictive effective level of care. And I think everybody agrees if you have the same treatment, the same level of care, and it's both the most effective and the least restrictive or the most effective and the least

intensive, that's the one you should choose.

The question is: What do you do when there is a conflict between two of the adjectives? What happens when the most effective level of care is not the least intensive, when it's more expensive than the second most effective treatment? And that, Your Honor, is where UBH failed as a fiduciary because it was supposed to put the member's interests first and that would require prioritizing "effective" over "least intensive," and time after time it didn't do that.

And you can see that -- actually, I want to turn now to the two words I think everyone in this courtroom is hoping never to hear again, and that is "why now." You can see from the face of the guidelines that UBH placed a disproportionate emphasis on "acuity" and that this was used to build a gauntlet that members had to make it through to be entitled to coverage.

Drs. Fishman and Plakun testified to the effect that the Court can look at the language of the guidelines and see for itself the pervasive underemphasis on chronicity and comorbidity and overemphasis on acuity. Now, this is not to say that someone using the guidelines might not have information about a patient's chronic symptoms and comorbidities. It's saying that overall, the emphasis of the coverage criteria is heavily skewed towards acute, towards the "why now."

I want to turn to common criteria, Level of Care

Guidelines 2015, 1.4 to 1.6, "Member's Current Condition," and we've been over and over these provisions, so I'm not going to dwell on them too long.

Here you have "why now," the "why now" factors leading to admission, defined to the acute -- as "the acute changes in the member's signs and symptoms and/or psychosocial and environmental factors." And the term "why now" appears over 80 times in the 2014 Level of Care Guidelines and then over a hundred times in 2015 and 2016.

And then you have the focus on acuity, and in 1.6 the reference to comorbidities, both behavioral health and medical conditions. And as we have noted repeatedly now, the co-occurring behavioral health and medical conditions are supposed to be able to be safely managed; whereas, the acute changes or the current condition is supposed to be able to be safely, efficiently, and effectively assessed and/or treated.

Words matter. Safe management is not the same thing as effective treatment. We know that UBH knows how to say "effective treatment" because it's included in 1.4 and 1.5. So the fact that they do not use that phrase in 1.6 is significant. It's like the doctrine of statutory interpretation. When Congress knows how to use certain language and chooses not to, we presume that it does so for a reason and that the different language has a different meaning.

Can we go down in this document to the best practices? I

think that's on page 10.

Now, UBH runs away from much of the language in its guidelines in this case, but it runs toward best practices, embraces the best practices. And there is a lot of important information in here that the provider is supposed to collect and the care advocate is supposed to ask for. We note that 4.1.2.3 directs the provider to collect information about the "why now" factors leading to the request for service.

And can you go through the whole list, please?

You'll note that the "why now" information is one factor among many side by side with information about comorbidities, personal family history, barriers to treatment.

So the question is: If all those factors, if all that information is already baked into "why now," why are they listed separately in this list? More evidence that the phrase "why now" does not mean what the defendant now says it does.

But additional evidence that the phrase "why now" promotes a focus on the acute over the chronic comes from its historic origins, and the evidence is that this phrase and the impetus for UBH's clinical vision came from Dr. Bonfield, who was UBH's chief medical officer until earlier this year and whose video testimony was played in the courtroom yesterday.

He testified that he got the concept of "why now" from crisis intervention literature. So right there the concept originated from an inherently acute level of care. He further

testified that "why now" was, quote, "a pretty immediate issue" and, quote, "not something that happened 10 years ago," and he gave an example of what "why now" meant. His example was somebody who had long-term depression, and that depression is aggravated when he discovers that his wife has been having an affair. The depression in that example is the chronic condition. The learning of his wife's infidelity is the "why now" factor.

So long-term depression, whatever biological or historical factors that led to it, whatever comorbid issues are wrapped up in it, are not included in the concept of "why now," which is limited to the immediate trigger that precipitated the aggravation of the preexisting condition. And that, Your Honor, is the very definition of "acuity."

Another way to know that why --

THE COURT: So what's wrong with that?

MR. GOELMAN: It's directly in conflict with the testimony from UBH's employees that "why now" incorporates everything under the sun.

THE COURT: I see.

MR. GOELMAN: I want to turn to another guideline. This is Exhibit 148, 2015 Custodial Care and Inpatient Residential Service CDG under the "Key Points."

Here we see under "Custodial Treatment" and then "Active Treatment" -- can you go down a little bit more in "Active

Treatment," please -- a citation -- under "Improvement," a citation to CMS Local Coverage Determination, and also for "active treatment" a citation to CMS LCD, and then in the text of "active treatment" in the bullet it says (reading):

"Active treatment is indicated by services that are all of the following..."

And here the CMS Benefit Policy Manual, Chapter 2, is cited. Again, another example of a source that is distorted, and this CDG is for Custodial Care and Inpatient Residential Service, so it is not simply for inpatient.

Can you go to the top, please. Right.

It's citing the CMS Psychiatric Inpatient Local Coverage Determination, but this is a CDG that is supposed to apply also to residential, and that gets into the difference in the ASAM residential levels of care.

And Dr. Fishman explained when he was shown this CDG that features of this level of care are akin to an ASAM Level 3.7, which is the most intensive residential level of care for substance use disorders; but Dr. Fishman also testified that they're way too restrictive for lower levels, like 3.5 and 3.1.

And, again, contemporaneous evidence shows that not only was Dr. Fishman right, but that UBH knew that he was right, knew that they didn't comply with ASAM back at least until -- at least since 2013.

And Exhibit 412 at 13 is the Crosswalk that Dr. Alam got

from Mr. Shulman, and it shows -- and I think the Court probably remembers this testimony -- Mr. Shulman gets the guidelines, and he calls Dr. Alam up and he says, "Wait a minute. Where's the criteria for all the other residential levels under ASAM?"

And Dr. Alam tells Mr. Shulman falsely that the plans don't cover that. And then UBH tells Connecticut, again falsely, that its Level of Care Guidelines do provide for coverage of the lower residential levels of care under ASAM.

So UBH tells its regulators one thing, its ASAM consultants something else, and then comes here and tells the Court something altogether different; meanwhile, its internal e-mails show that it recognizes the truth. And, yet, the defendant still asks this Court for the benefit of the doubt, still claims a defense of good faith.

It's not just the overemphasis on acuity, the failure to adequately account for chronic conditions and comorbidities. The guidelines violated generally accepted standards because they had one set of criteria for everyone, including children and adolescents. But the evidence is that for the purpose of mental health, mental illness, substance abuse, kids are not just little adults. This evidence is uncontroverted. Children present differently, and the treatment appropriate for an adult may not be appropriate for a child with the same symptoms.

For this reason, those resources that everybody recognizes

as reflections of the generally accepted standards -- ASAM, CALOCUS, CASII -- all of them have differing criteria for children and adults. UBH does not and this is not in dispute.

What is UBH's response? They say they know how old the beneficiary is and their care advocates or medical directors take that into account somehow. But how?

As Dr. Allchin conceded, there's nothing in UBH's guidelines that tells the clinician to use the information collected in a way that varies the coverage criteria from the way they're used for adults. That's a clear-cut departure from the standard of care. UBH should have separate guidelines for kids or at least separate criteria for children. They do not. That's inconsistent with the generally accepted standards.

I mentioned earlier that if UBH thinks that the evidentiary record in this case is consistent with its good faith, it has a very different idea of the meaning of the term "good faith" in most English speakers, but it's just one example of the bizarre linguistic positions that we've heard UBH and its witnesses adopt in this trial.

Their effort to defend the guidelines to persuade this Court that the guidelines don't really mean what they say has led UBH to the following bizarre interpretation of common English phrases and words:

"Safely manage" has the same meaning as "effectively treat," "clear and compelling evidence" actually means

"reasonably likely." Time after time, witness after witness, the Court asked about these strange new takes on the English language, asked the witness why the guidelines said one thing when they really supposedly meant something else; and time after time, witness after witness, the Court didn't get a real answer. It got explanations like "Inartful drafting," or "That's the colloquial reading," or halfhearted concession "I wouldn't have written it like that," "I would approve that edit"; and it got simple denials, "That's not how I read it," or, "I just disagree."

But one thing the Court has not gotten is a real answer. Maybe counsel for UBH will have a coherent explanation in closing argument, but we certainly haven't heard it from any of the witnesses.

And another thing that we haven't heard from UBH is details. They can point to a lot of their doctors who they called to the stand and testified that it was their opinion that the guidelines conformed to generally accepted standards, but that's not good enough. You can't just incant the mantra "In my opinion, this is consistent with GASC, in my opinion, that is consistent with GASC" and expect that to have any weight.

So what explains all this? What explains UBH's extreme departures from the generally accepted standards of care? It's actually not a big mystery. The evidence has shown, as

Ms. Reynolds predicted in her opening statement, that UBH consistently sacrificed the interests of its beneficiaries to its own financial interests; that UBH, the desire to limit ben-ex trumps all.

First, it's undisputed that UBH operated with a structural conflict of interest. It is directly at risk for benefit expenses paid on its fully insured plans, and these plans are administered under the guidelines that UBH itself writes and maintains.

ERISA is clear that this isn't necessarily a problem but that a faithful fiduciary should wall off the people making the decisions from those concerned about financial considerations. That's why insurance company clinicians no longer get bonuses for the number of claims that they deny. And there's no evidence here that the individual care advocates and medical directors working for UBH were incentivized by these kind of goals, but that doesn't eliminate the conflict. It just kicks it upstairs.

The BPAC and the UMC had to approve the guidelines before their use. Minutes from these --

THE COURT: Before you get to that --

MR. GOELMAN: Yes.

THE COURT: -- this argument doesn't apply to the majority of plans; right?

MR. GOELMAN: "Majority of plans" meaning the ASO

plans?

THE COURT: Yeah, the ASO plans, which are the majority of the plans at issue in these benefit determinations, the majority of the benefit determinations, slight majority; 60 percent or 56 -- I can't remember what it is -- were determinations under nonrisk plans, the ASO plans.

MR. GOELMAN: UBH showed a slide in its opening, the 62-38 percent pie chart. We had planned to show a slide that showed 75 to 80 percent of the income came from the fully insured plans.

I think that neither of those evidence --

THE COURT: "Plan to" doesn't get you into the --

MR. GOELMAN: I don't think they entered their evidence either. I don't think there's any evidence and the record from the trial is devoid of those proportions.

THE COURT: Well, is there -- okay.

There's no evidence of proportions. There is evidence that --

Okay. Got it.

MR. GOELMAN: At UBH the need to consider the impact of guideline changes on ben-ex was not even controversial, it was assumed; and the influence of the bottom line on the terms of the guidelines was consistent, it was pervasive, not as UBH has tried to portray it episodic and rare. And, worse yet, there's no reason to believe that it's not still going on.

Exhibit 556 is the minutes from October 26 UMC meeting where a disturbing increase in monthly ben-ex was discussed. That was a year ago, more than two years after this lawsuit was filed. And what's UBH's response? Well, this committee does more than just vote on changes to the guidelines; but that, respectfully, is exactly the point. The committee who has oversight over the guidelines shouldn't be the same committee that is closely monitoring ben-ex.

In any event, the committee is not the real issue. The issue is how UBH makes decisions when there's a conflict, perceived or real, between the right answer clinically and the right answer for the bottom line. Here, the evidence is completely one-sided. When there's tension between clinical judgment and the bottom line, the evidence shows that the bottom line trumps every time.

You heard testimony about the way UBH manipulated the extent to which it would cause its plan to cover TMS, transcranial magnetic stimulation, and ABA for the reasons that have nothing to do with clinical reasons. It has nothing to do with generally accepted standards of care and everything to do with UBH's bottom line.

But perhaps no episode illustrates how completely subordinated clinical considerations are to financial considerations at UBH than the ASAM saga. And I call it a "saga" for a reason. Three times during the class period UBH

considered adopting the ASAM criteria for making level of care placement decisions for SUD patients. Each time the senior leadership, the nonclinical business leadership, made the decision not to do so. Each time that decision was based on pure naked consideration of UBH's financial self-interests.

The episode that we have the most evidence about was the 2013-2014 consideration of adopting ASAM. Then at that point in time the course in support of adopting ASAM included Jerry Shulman, UBH's consultant; SUDS Team 2, the ASAM subject matter experts. In fact, there was a consensus among all the addiction psychiatrists at UBH that adopting ASAM would be a good idea.

Here's Exhibit 430-002 from Dr. Rosenzweig to Dr. Triana. It says, among other things, "I think there is consensus among all the addiction psychiatrists that this would be a good idea," referring to adoption of ASAM.

So everyone on the clinical side was on the same page. This was a good idea clinically. What was the opposition? Again, concern about ben-ex.

Exhibit 382, please.

This is the minutes and agenda for the SUDS clinical protocol meeting on June 10th, 2013, talking about the adoption of ASAM. There's a cost analysis impact on utilization management and process, concern from leaders that we do due diligence in an attempt to determine if any ben-ex impact.

So they weren't sure that it was going to have a huge benefit -- a huge impact on ben-ex, but just the concern was enough to block the adoption of criteria that was supported by all the addiction psychiatrists.

What did the addiction psychiatrists do? They knew that the only way that ASAM would be adopted is if they could prove to the higher-ups that there would be no impact on ben-ex or that UBH would actually make money by adopting ASAM.

So someone had the idea "Let's do a pilot program." This is Exhibit 452, and it is a part of a deck for the SUDS team. This is a clinical protocol project that Dr. Alam was in charge of (reading):

> "The issue is that there's no utilization ben-ex data allowing meaningful comparison for ASAM versus Optum SUDS criteria sets. So what is the solution? Let's do a test. Collect relevant UM data with utilization and ben-ex summaries at three- and six-month periods. If utilization is same or less for ASAM, continue rollout/expand pilot."

What was the plan if this pilot program utilization was more for ASAM instead of being the same or less than for UBH's guidelines? The plan, as Dr. Alam conceded on the stand, transcript at 1669, 1 through 5, was to abandon ship (reading):

> **"QUESTION:** Conversely, if utilization was more for ASAM, then the rollout would not be continued, would not be expanded, it would be terminated; correct?

"ANSWER: Yes."

Right there, that shows you all you need to know about what trumps what at UBH. This is a SUDS team document. These are the subject matter experts. They support adoption of ASAM and they know that if there's any negative impact on ben-ex, the company won't do it. It doesn't matter how many states, professional groups, how many of their own clinical folks tell them that it's the right thing to do, that ASAM is clinically superior. All that goes out the window. All that has zero impact if there is even the possibility that ben-ex could be impacted.

Now, I said earlier that the Court shouldn't credit Dr. Simpatico's testimony at all. I actually want to amend that because Dr. Simpatico did have a brief lapse into candor when the Court was asking him about his opinion that "clear and compelling" means "reasonably likely."

Dr. Simpatico said (reading):

> "Well, I guess I would take a step back and say the following: Any practitioner worth their salt, if they are referring to practice guidelines to conduct the art of the practice of medicine, then that's a bigger problem. So I would not be looking at these documents to make clinical judgments about how -- whether or not to discharge someone to another level of care."

That was an extraordinary moment. Defendant's principal

expert, their only independent expert, started working with UBH on this case long before trial, that guy testified that he wouldn't use the guidelines to make clinical judgments about level-of-care decisions.

You know what? That just means that Dr. Simpatico, while he was an awful expert witness, is probably a pretty good doctor because these documents that Dr. Simpatico dismissed after spending two days extolling their virtue, these guidelines, to use a legal term of art, they stink. They represent an extreme departure from the generally accepted standards, they hamper the providers who care for UBH's beneficiaries, and they do a grave disservice to the beneficiaries themselves, the very people that UBH is supposed to administer their plans solely for the benefit of.

THE COURT: So you're done?

MR. GOELMAN: I'm done, Your Honor.

THE COURT: And how long do you think you're going to go?

MR. RUTHERFORD: Just one hour, Your Honor. Give or take a minute, but that's what I think.

THE COURT: All right. Okay. Go ahead.

CLOSING ARGUMENT

MR. RUTHERFORD: Good morning, Your Honor.

UBH didn't breach its fiduciary duty to its members. It didn't wrongfully deny benefits to the class, not in any of the

years from 2011 to 2017, not under any of the plans, and not by creating or using any of the guidelines.

UBH was granted discretion in each of the plans at issue. In this case, to promulgate and apply guidelines for the purpose of determining coverage for its members. UBH acted within that discretion during each year at issue and under each guideline.

The terms of the plans in this case define and limit benefits sometimes in a manner that may differ from generally accepted standards of care, and that's not a violation of ERISA.

We're not limited by the terms of the plan. UBH had discretion to create and use guidelines to make coverage decisions. It was not required to adopt third-party guidelines for every commercial member across the country, and it was not required to use certain words. It was required to act in accordance with the plans and its duties as a fiduciary, which require faithfulness to the members but not perfection.

Much time was spent in this trial examining the specific words and provisions within eight Level of Care Guidelines and seven Coverage Determination Guidelines. Retained expert witnesses and UBH's in-house clinicians focused on the words and their provisions, their meanings, and their use. And the evidence showed differences of opinions about the meanings of many words and provisions and how they might be used by UBH's

clinicians and about whether the words and provisions were consistent with the plans and generally accepted standards of care.

But what the evidence also showed was that even with these differences of opinion, UBH's promulgation and use of the guidelines fell within its discretion; and that regarding the specific words and provisions at issue in this case, which I'll get to, UBH did not elevate its own financial interests above the interests of its members and that it engaged in a process that was intended to produce guidelines that were consistent with generally accepted standards of care in the plans, and that it did, in fact, produce guidelines that were consistent with generally accepted standards of care in the plans.

Now, before trial began, the Court framed the issues to be tried in this case with a number of key questions, and today we're going to focus on six of those questions and we'll be saving some of the others, Your Honor, for posttrial briefing.

Now, it was plaintiffs' burden to prove each of the elements of each of their causes of action and then to prove a right to the relief sought. Plaintiffs haven't satisfied their burden, including with respect to class-wide proof.

So what I'm going to do for the next hour is review the evidence about the plans, I'll review what the law and the evidence says about the standard of review that UBH believes should apply, and then I'm going to address the guidelines

challenged in this case, and then finally the process that UBH used to create and update those guidelines and how that demonstrates that UBH didn't abuse its discretion under the plans.

Now, this case, as we said in our opening statement, is about UBH's obligations under the terms of a thousand health benefit plans. It's the plans that govern a class member's right to coverage and it's the plans that govern plaintiffs' claims.

111 of those plans came into evidence in this case, and three of the Court's questions, pretrial questions, speak directly to what the written terms of those plans say.

First, did the plans of the class provide coverage for treatment that's within generally accepted standards of care?

Second, were the guidelines at issue inconsistent with the plans?

Third, was UBH acting as a fiduciary when it promulgated the guidelines at issue or was it just acting as a settlor?

Now, like ERISA itself, we'll begin today by focusing on what the evidence showed about the plans in each one of these threshold questions. So let's go to the first question.

Did the plans of the class provide coverage for treatment that's within generally accepted standards of care? The evidence in UBH's opinion is uncontroverted. The plans do not provide coverage for all treatment that's within generally

accepted standards of care.

In a case about whether UBH abused its discretion in interpreting the class members' plans, plaintiffs gave the Court no evidence about what the plans mean. Instead, the only evidence the Court heard from plaintiffs about the plans is that specific phrases relating to generally accepted standards of care appear on specific pages and in specific sections of each of the plans at issue -- I mean, I'm sorry -- each of the plans that are actually in evidence.

THE COURT: Do you agree that it is a necessary but not sufficient condition to coverage under all of the plans that the treatment at issue be consistent with generally accepted standards of care?

MR. RUTHERFORD: Yes, Your Honor. It's one condition but not the only condition.

THE COURT: So every plan, every plan requires as a condition -- not the only condition, there are other conditions, there are other exclusions -- requires that the treatment at issue be consistent with the generally accepted standards of care?

MR. RUTHERFORD: Yes. And I'm going --

THE COURT: And the generally accepted standards of care in terms of level of treatment are defined by UBH in its Level of Care Guidelines?

MR. RUTHERFORD: Yes.

THE COURT: Okay. Thank you.

MR. RUTHERFORD: Now, through the testimony of their summary witness, Ms. Duh, plaintiffs offered evidence that each of the plans included specific phrases relating to generally accepted standards of care; but Ms. Duh did not offer any expert testimony about what the plans mean, the specific phrases -- what the specific phrases she identified mean, and how those phrases regarding generally accepted standards of care fit within the plans, or whether the plans cover all treatment that's consistent with generally accepted standards of care.

By contrast, UBH offered the testimony of Barry Dehlin, director of product strategy for UnitedHealthcare. Mr. Dehlin is the only witness in this case who testified about what the plans mean, including the specific aspects of the plans that are relevant to the issues in this case.

Mr. Dehlin confirmed that there is no requirement that the plans cover all treatment that falls within the scope of generally accepted standards of care.

Mr. Dehlin further explained that in order to understand what is covered under the plans, one would need to look -- I'm sorry, Your Honor -- one would lead -- I'm sorry -- one would --

THE COURT: So I don't think anyone disputes what you're saying.

MR. RUTHERFORD: I need to get some water.

THE COURT: Yes. Go ahead. Please.

So while you're taking care of that, I don't think anyone disputes what you're saying. I don't think anyone disputes the notion that the plans do not have coverage, all of them, for all treatment that is within generally accepted standards of care. No one disputes that.

MR. RUTHERFORD: Okay.

THE COURT: The question is not that. The question is the one that you answered, which is it's a condition that it be generally accepted standards of care. There are others.

Now, there are other exclusions. Why does that matter to me that there are other conditions to coverage or there are other exclusions? Why do I care?

MR. RUTHERFORD: Well, it's going to matter in part because of the issue of class-wide proof, Your Honor. So --

THE COURT: Go ahead.

MR. RUTHERFORD: So -- and I'm -- so back to Mr. Dehlin. So Mr. Dehlin further explained that in order to understand what's actually covered to this point, one would need to look at five factors: The covered services section of each of the plans; the excluded services section of each of the plans; the definition section of each of the plans; and for any additional riders to those covered services, exclusions, and definitions; and any additional amendments to those covered

services, exclusions, and definitions.

Plaintiffs argue that the plans require guidelines that are consistent with generally accepted standards of care; to the Court's point. But plaintiffs didn't offer the class-wide proof to support this argument that each applies in the same way to each class member because of the differences in the plans that the plaintiffs didn't put into evidence.

THE COURT: I don't understand that argument at all.

Plaintiffs' argument here is that one of the conditions --

MR. RUTHERFORD: Yes.

THE COURT: -- not a sufficient condition for coverage, but a necessary condition, as you just said, is that it be a generally accepted standard of care treatment. You define it through your Level of Care Guidelines. That's what UBH does.

Their point is that if you're going to give guidance to the people making coverage determinations on what is generally accepted standards of care, it better be generally accepted standards of care; not that there is actually coverage.

And I decided early on that they don't have to show that there's actually coverage for any particular person or any particular this or any particular that. Right?

So I don't know why it matters that to decide, ultimately, what the coverage is I have to go through the plans. Of course. That's how do you insurance. You'd have to go through

every plan and figure out for a particular treatment whether or not it's a covered service as defined by the plan; it's not an excluded one, and there aren't any riders that change it. Of course.

But why do I have to go through any of that in this case?

MR. RUTHERFORD: I'm going to get to this later with custodial care, but custodial care is a definition defined by the plan.

And with respect to custodial care, we're going to point out that the definition of custodial care is essentially a plan-defined benefit.

THE COURT: So let me ask you about that.

What are CDGs?

MR. RUTHERFORD: They are the coverage determination guidelines that are used when there is not a medical necessity provision in the health plan.

THE COURT: Okay. And I'm not sure what you mean by there's no medical necessity condition in the health plan, since all of the plans require that the treatment be, as a condition, consistent with medical necessity. I mean, I have no idea what that means.

But the CDGs don't apply to every healthcare plan; that's right.

MR. RUTHERFORD: Right.

THE COURT: Doesn't apply, for example, to the ASO

business. Is that right?

MR. RUTHERFORD: That I don't know the answer to, Your Honor. Somebody else might, but I don't.

THE COURT: The certificates of coverage that are quoted in the CDGs, that's all for the risk business.

MR. RUTHERFORD: That's true, Your Honor, yes.

THE COURT: So to the extent the CDGs are drawn from the actual plan language, as quoted in the CDGs --

MR. RUTHERFORD: Yes.

THE COURT: -- it's not from the ASO business; right?

MR. RUTHERFORD: Yes, Your Honor.

THE COURT: Just from the CDGs, just from the risk business. That's right.

MR. RUTHERFORD: Yes.

THE COURT: So, I guess, my concern is that I don't understand the role that you see, this differing role for the CDGs and the -- and the Level of Care Guidelines, because the plans all have some reference to the generally accepted standards of care in the plans.

MS. ROMANO: Your Honor, might I provide a little bit of detail on this one?

THE COURT: Sure.

MS. ROMANO: First of all, I want to just clarify that ASOs, the self-insured plans, are also under ERISA. So the ASOs and fully insured plans are both under ERISA.

THE COURT: Of course. I understand that.

MS. ROMANO: And, for the most part, United Healthcare plans during certain periods of time included certain language in them for which it --

THE COURT: You mean the risk business.

MS. ROMANO: I'm sorry -- well, all risk business is not necessarily United Healthcare business.

THE COURT: Okay. You mean both kinds of plans.

MS. ROMANO: Yes.

But for some fully insured plans, where United Healthcare was providing the medical and surgical benefits, UBH was managing those for them, fully insured.

For many of those plans, during certain periods of time their was certain language in those plans that would then dictate the coverage determination guidelines would be used for making decisions under those plans.

For ASOs or self-insured plans, some of them also came through United Healthcare, also used some of the same language, and also would have resulted in coverage determination guidelines being used as well.

And there was certain language that would trigger whether a level of care guideline or a coverage determination guideline would be used for the plans.

I don't have the number with me right now, but my understanding is it's approximately half of the plans for the

class members at issue in this case used coverage determination guidelines, and half used -- or half of the class members had a coverage determination guideline used, and approximately half had a level of care guideline used.

THE COURT: So, I guess, I'm still a little confused.

The CDGs that were -- we've gone through and are in evidence all quote from certificates of coverage. Those certificates of coverage are for the risk business -- right? -- not for the ASO business.

MS. ROMANO: The actual language they are quoting there, where it says "COC," that refers to a certificate of coverage, which would be a fully insured plan.

THE COURT: Okay.

MS. ROMANO: Although, there are some ASOs or self-insured plans that would have had similar language and that might have, because of language in the plan, driven the use of a CDG versus a level of care guideline.

THE COURT: All right. Thank you.

Okay.

MR. RUTHERFORD: And this leads to the Court's next question: Were the guidelines at issue inconsistent with the plans?

And we just discussed that the plaintiffs didn't offer any evidence about what the plans mean or what the plans require.

But even if the Court considers the testimony and summary

evidence of Ms. Duh -- who was the witness, Your Honor, who put together the summary for the plaintiffs -- plaintiffs didn't offer any evidence about whether or not the guidelines are consistent with the plans.

The plaintiffs called two experts mentioned just a moment ago by Mr. Goelman. And that is Dr. Fishman and Dr. Plakun. But neither of those experts offered any opinions about whether or not the guidelines are consistent with the plans. And both of them conceded that neither one of them had reviewed the plans in preparation for their expert testimony in this case.

THE COURT: I wish I had those pictures.

(Laughter)

THE COURT: No, it helps, you know, to get a visual.

But you just admitted that all of the plans require, as a condition of coverage, that the treatment be consistent with generally accepted standards of care. It's not a big admission. It's what you had to say.

And they testified that the guidelines were inconsistent with the generally accepted standards of care. Why isn't that enough? Why do they have to go down to the plan level?

MR. RUTHERFORD: Well, back -- it's essentially back to the point I made a few moments ago, Your Honor, which is that with respect to what is covered -- that essentially there's going to be a difference, depending upon the plan, as to what ends up getting covered --

THE COURT: Again, why do I care what's being covered?

MR. RUTHERFORD: I think again, Your Honor, this goes to the issue of whether or not the claims are being proven on a class-wide basis.

So, for instance, if the definitions of custodial care or coverage for maintenance of long-term care, or the like, change within the plans, I believe that that is important for the analysis of whether or not the plaintiffs have proven the class wide -- made --

THE COURT: Why?

MR. RUTHERFORD: I'm sorry, Your Honor.

THE COURT: Why? I don't understand. Their class-wide proof is this:

All the plans require that, as a condition of coverage, that the treatment be in accordance with generally accepted standards of care. That's every plan. Everybody stipulated to that.

Second, these are the Level of Care Guidelines. They're not consistent with generally accepted standards of care.

Third, the Level of Care Guidelines are incorporated into the CDGs.

Fourth, the Level of Care Guidelines and the CDGs were applied in denying these 212, and these seven or eight, were applied in denying all of these.

That's their class-wide proof. Why do I have to go down

to the level you're talking about and talk about whether or not in a particular plan there's coverage? Or a particular service?

This is -- as you always said, this is a facial challenge. And no one has put in any evidence about a particular person's denial being wrongful because there was, in fact, coverage.

This is about the process used. That's what this case is about. It's about the process used.

Why do I care that, yes, insurance plans are complicated?

MR. RUTHERFORD: Well, I may just save this point for post-trial briefing, Your Honor.

But I think the basic point we are making -- and maybe we will just need to persuade the Court in writing -- is that the limits, the varying limits, limitations and language within the plan -- within the plans, do make a difference with respect to the plaintiffs' ability to meet their burden on class-wide proof.

THE COURT: You keep saying that. You don't have the slightest answer to me what that means.

MR. RUTHERFORD: Number one --

THE COURT: What class-wide proof do they need that they don't have? What do they need to show for the class that you think they don't show?

MR. RUTHERFORD: To take a definition like custodial care and have that definition be consistent you, if that's what

they are going to claim is inconsistent with generally accepted standards of care, to have that definition be consistent through all 111 plans at issue.

To take the definition of coverage for maintenance or long-term care, or the definition of less intensive or more cost effective alternatives, or whether there is residential treatment available under a plan to be consistent.

THE COURT: Why? I guess I don't understand any of that. That makes no sense to me.

Here's where I think the flaw is: The only way I think you can make this argument is by saying that, actually, the language of the guidelines -- and I think you have made this argument -- the CDGs are driven by individual plan language from year to year.

MR. RUTHERFORD: That would be true.

THE COURT: True, false, I don't know.

MR. RUTHERFORD: That's the position.

THE COURT: That's the position.

That's the only thing that makes any sense to me about whether or not -- and I think the plaintiffs are going to have to answer that question. Why should I examine the coverage determination guideline for custodial care when the custodial care guideline says that it draws its language from a coverage determination -- from a certificate of coverage?

That's the problem for the plaintiff with that one. And

I'm not sure what the answer is other than that they will say this, they will say this:

It's also a condition of every one of those plans that you go through a process to satisfy one condition -- that is to say, the treatment is consistent with generally accepted standards of care -- and that the way in which you do that is through the Level of Care Guidelines, either directly, because you refer to them and you look at them, or through the incorporation in the CDGs.

And that the Level of Care Guidelines language is not -- there is no testimony that that's driven by the plan language, by the plan exclusions, et cetera. The Level of Care Guidelines are to help the practitioner decide what is, in their clinical judgment, within the generally accepted standards of care. Then they go to the other steps, through the rest of the CDG, which may be driven by plan language.

But that's -- that's their proof. That's their proof. Why do they need to do more than that? Why do they need to say anything about the individual plan language for custodial care?

It's not your usual closing argument, I guess.

(Laughter)

MR. RUTHERFORD: I know. Much like this trial, it might not be the one I planned for.

THE COURT: Right.

MR. RUTHERFORD: Maybe I'll just say this and then

move on to the next point.

Our position is that to prove the breach of fiduciary duty in denial of benefits, the benefits must actually deny benefits -- never mind, Your Honor. I'm just going to move on to the next point.

THE COURT: Let me ask one other question. I want to make sure one thing is true.

You're not arguing that they had to put in evidence on all 1,000 plans.

MR. RUTHERFORD: No.

THE COURT: If they had to prove up anything about individual plans, we all agree that it can be proved up through the sample plans that are in evidence; and that will be taken as a representative sample for the entire class.

Do we agree to that?

MS. ROMANO: With one clarification.

When we did the discovery stipulation, and whatnot, we did not agree it was a representative sample. But given the Court's remarks at the pretrial conference, with respect to the fact that we only produced what we produced, that this trial and the decisions in it would be limited to those plans at issue and those that were admitted in this trial.

THE COURT: So I'm not sure. If that's an actual caveat, I'm not accepting it. That's an explanation for how we got there.

But I want to make sure that right now UBH is stipulating that to the extent that there are any individual plan issues, they have to be decided. And the plans are in. And the plans are in even -- you have to look at them for plaintiffs' case even in their high-level case; right? You have to show the provision that talks about generally accepted levels of care, or whatever it is.

We can look at, for any issue that regards individual plans, the sample that was put into evidence is binding on UBH for the entire class.

That is to say, I don't have to look at -- that the only argument will be that sample; it will not be about outside the sample. And that the sample is, for all purposes, a representative sample of the entire class.

MS. ROMANO: For purposes of this case, yes.

THE COURT: For purposes of this case. The other cases I don't care.

(Laughter)

THE COURT: Okay. Thank you.

MR. RUTHERFORD: Okay. Then let me just put this final statement on the record, Your Honor, and then I'm going to move on.

So our position on this, for the record, would be that to prove a breach of the fiduciary duty and denial of benefits there must be proof that there was an actual denial of benefits

in breach of the actual plans.

I think that is the concept --

THE COURT: No, you've said that from the beginning. I understand that.

MR. RUTHERFORD: All right.

Now, to the standard of review for evaluating the claims.

THE COURT: Yeah.

MR. RUTHERFORD: There's going to be some law in here, Your Honor, that I'm going to cite just because I'm used to jury instructions. And this was the -- sort of the best way that we could come to formulate it. But we will be briefing these issues as well.

Now, as Mr. Dehlin explained, the plans in evidence give UBH discretion to interpret their plans. And, accordingly, the standards of review, in our view, is, for all plaintiffs' claims, abuse of discretion.

This deferential standard of review is critical because it provides the lens through which all of the evidence must be viewed.

We submit that the question for this Court is not whose interpretation of the plans is most persuasive or whether or not the Court would have interpreted the plans differently or even written different guidelines, and not whether the guidelines are a perfect reflection of generally accepted standards of care.

The question, in our view, is whether or not UBH's interpretation of each of those plans is reflected in the guidelines as an abuse of discretion. In other words, whether it was unreasonable, or however the law states that -- that particular definition.

THE COURT: "However the law states that."

MR. RUTHERFORD: Well, there's different cases.

But the case that I have, for instance, on the -- on the screen, which is not the only case on point, is that the question is whether the administrator's interpretation was illogical, implausible, or without support, and inferences that may be drawn from facts in the record.

And I think there's similar language in other cases. But the idea behind it is that it's an abuse of discretion.

THE COURT: Right.

MR. RUTHERFORD: Plaintiffs argue that the Court should apply a significant amount of scepticism -- I don't know exactly what the phrase Mr. Goelman used was -- but some scepticism to UBH's exercise of discretion, because UBH had a conflict of interest that systematically incentivized UBH to create restrictive guidelines.

So that leads us to the Court's next question which was: Did UBH operate under a conflict of interest when it promulgated the guidelines and/or denied the benefits to the class? And did that conflict, if any, affect the decision

promulgating or using the guidelines?

Now, to the question that the Court asked before, with respect to the conflict -- and I'm going to talk about in a second -- that is a conflict that does exist only with respect to the fully insured plans.

But, as the Court pointed out -- I think it might have been during opening statements -- the guidelines are written for all of the plans, both the fully insured and the self-insured.

THE COURT: So that means the conflict applies to all of the guidelines; right?

MR. RUTHERFORD: We're essentially going to -- the Court can draw that, but we're -- we're going to assume, in the comments that I make right now, that they do.

THE COURT: Okay.

MR. RUTHERFORD: And the question here has two components: The first, whether or not UBH has the conflict of interest in the sense that it acted in the dual role of administering the benefits and funding the ERISA plan. And as I've just said, with respect to the fully insured it did, which is not unusual, as the Court probably knows, from managed care companies.

But the fact that UBH operated under this structure of conflict of interest with respect to its fully insured plans doesn't by itself change the standards of review.

In fact, for managed care companies like UBH, structural conflict of interests like this can be mitigated by the fact that most or all of the cost is passed on to others. And plaintiffs bear the burden of proving that this structural conflict of interest actually affected the content of the guidelines at issue in this case.

And this is why the second component of the Court's question is so important. Did the conflict, if any, the structural conflict, affect UBH's decision in promulgating or using the guidelines?

Now, of course, UBH considers and the evidence shows that benefit -- considers benefit expense and utilization trends such as average length of stay. Plaintiffs say it's a bad thing. UBH contends that it's not.

The Court heard evidence from UBH's witnesses confirming that it's not only appropriate but necessary for UBH, as a company, to be aware of the costs of providing services. In fact, UBH has a fiduciary duty under ERISA to defray reasonable expenses of administering the plans.

UBH also has a fiduciary duty to enforce plan terms, including plan terms that relate to -- that require UBH, I'm sorry, to consider the cost of services.

Now, as Dr. Brock, UBH's former senior vice president of affordability explained, UBH is a managed care company. And part of its job is to manage costs. That's what employers hire

UBH to do.

As Dr. Triana testified, employers consider cost among other things when choosing a plan, and they expect to know how much the product they are purchasing will cost. That's the healthcare system that we have in this country.

And this isn't just something that UBH focuses on. The idea of managing costs in healthcare is a national focus, seen directly through CMS and the triple aims of managed care: improving quality, improving outcomes, and reducing costs.

According to Dr. Brock, UBH focuses on developing and implementing solutions to service system problems that address the triple aims.

Dr. Brock testified, UBH employees' data about utilization, including average length of stay, benefit expense, and readmission rates, among other things, formulate healthcare quality and affordability initiatives or service system solutions to better serve members and reduce cost, waste, and fraud.

UBH's solutions and initiatives are not just about watching costs; which, again, is one of the triple aims. But they focus on promoting evidence-based care to improve quality. That has an added benefit of reducing costs because, as Dr. Brock explained in his testimony, improving quality reduces the cost of care.

Now, in contrast, plaintiffs offered no evidence that it's

improper or inappropriate for UBH, as a company, to consider benefit expense or average length of stay.

THE COURT: Let's talk about that.

MR. RUTHERFORD: Yes, Your Honor.

THE COURT: You know that's always an introduction to a question.

(Laughter)

MR. RUTHERFORD: Okay.

THE COURT: So, you know, I don't know that I disagree with anything you said in the last couple of minutes as a general proposition.

MR. RUTHERFORD: Yes, Your Honor.

THE COURT: But the proposition here is very specific. It is: In determining whether or not the generally accepted level of care, the treatment level that is proposed, is consistent with generally accepted level of care, as required by the plans, in deciding -- making that interpretation, you're not allowed to consider costs in deciding that. That's not a benefit. That's not a decision of coverage.

The plan says one condition of coverage is it shall be consistent with generally accepted; or it's exclude, it's not consistent with generally accepted standards of care.

In deciding that issue -- what is the generally accepted standard of care, and does this fall outside the generally accepted standard of care, putting in a residential program,

3.7, 3.5, whatever it is -- you don't get to consider money when you're doing that, do you?

MR. RUTHERFORD: Well, first of all, I don't think that -- I'm going to explain in a second, the evidence in this case was very specific with respect to when benefit expense was considered.

And with respect to the -- and I'll get to this in a moment, but with respect to the guideline provisions at issue in this case, as opposed to other guideline provisions that aren't, we would submit that the evidence does not show that benefit expense or average length of stay was considered.

THE COURT: What about ASAM?

MR. RUTHERFORD: Well, I'm going to talk about --

THE COURT: That's the one I think you have the biggest problem with, is that the ASAM is about adopting those guidelines for -- to determine level of care you made a decision not to adopt them on several occasions. And it looks like, from the evidence, that you clearly decided not to adopt them -- or at least your concern in whether to adopt them was driven in part by money.

MR. RUTHERFORD: I believe what the evidence will show -- and I'll get to that in just a second, Your Honor -- is that the decision not to adopt ASAM was a decision that was based at least in part -- and this is what the evidence showed, I'd submit -- because the benefit expense could not be

determined.

And the evidence further showed that it was important, given the fact -- well, it was -- it was important for UBH to be able to convey to its customers the health plans, whether or not there would be a benefit expense change.

Now, there was -- I'm sorry, Your Honor.

THE COURT: I don't know how that works. What were you considering adopting ASAM as?

MR. RUTHERFORD: Wholesale change to essentially an entire business model.

So if you look at the Level of Care Guidelines, you would take out that whole second section.

THE COURT: Right. And put in ASAM.

MR. RUTHERFORD: Right.

THE COURT: So you were going to replace part of the level of care guidelines?

MR. RUTHERFORD: Yes.

THE COURT: Wholesale with ASAM?

MR. RUTHERFORD: Yes, Your Honor.

THE COURT: Okay. Why, in deciding whether or not ASAM should be put in, because it is consistent with the level of care, generally accepted standards of care, do you get to include in that question money in the formula? Right?

The Level of Care Guidelines are just used -- they're not used to determine the ultimate decision on whether somebody

gets a benefit. They are the first step. They are a necessary but not sufficient condition. Is this consistent with generally accepted standards of care?

You look at the various choices and you decide, we'll put this in; we won't put that in. One suggestion is, let's put ASAM in because it's the gold standard for generally accepted standards of care.

Why, in deciding whether or not something is within the generally accepted standard of care, do you ever get to consider money?

MR. RUTHERFORD: Because if you have a thousand health benefit plans that you're working with, some percentage of which are going to incur the cost of any change to the extent that there is a change upward, and the others -- will incur the cost directly by having to pay the benefits. And then the other whatever the percentage is of the plans, will potentially see that cost in a premium. I think it is reasonable, given -- it is reasonable for United Healthcare to be able to calculate the impact from a financial standpoint, to be able to communicate to the plans whether there's going to be an effect; and, if so, what is it likely to be.

THE COURT: And to turn it down if it's going to be an increase. Because that's the import -- that's what Dr. Alam's committee thought. He thought if -- if it was going to be an increase in ben-ex, it was going to be an increased financial

burden, we're stopping. Right?

MR. RUTHERFORD: The testimony that he gave, which we saw in the transcript this morning, is the testimony that he gave.

The analysis, as I saw it, was that -- or what I believe the evidence showed, was that in each instance the calculation as to whether or not to adopt ASAM was a clinical one; that the understanding of the clinicians within UBH, at least the clinicians who are speaking to the cross walk that Mr. Shulman created, was that but for the identified levels of care at -- I don't remember, 3.5 and 3.1, that their criteria were otherwise consistent with ASAM. So that's what begins the discussion.

The next stage is to be able to calculate, because you have to be a responsible business to your customers, meaning the plans, is there going to be a difference?

And I think it is reasonable for UBH to have taken the position that we need to be able to understand if there's a difference so that when somebody asks, we can say more than, well, our doctors looked at the ASAM Criteria and our own criteria, and they think it's going to be the same.

THE COURT: Let's assume you're right, that they are allowed to do that. What are the implications of that position?

That means, in your view, in deciding whether something is within the generally accepted standard of care, as required by

a condition of coverage of the plan, you are always allowed to evaluate benefit expense.

MR. RUTHERFORD: I'm saying, Your Honor, that --

THE COURT: Isn't that -- I know what you're saying. But if you can examine benefit expense with respect to this change in whether something is within generally accepted standards of care, the next change for generally accepted standards of care will judge not just by whether or not it's generally accepted standards of care, it's by whether it costs more money.

You're saying you're always allowed to do that. Is that right?

MR. RUTHERFORD: What I'm saying --

THE COURT: Is that right or wrong?

MR. RUTHERFORD: No, Your Honor, that's not right.

What I'm saying right now --

THE COURT: Why isn't that the necessary implication of what you just said about ASAM?

MR. RUTHERFORD: Because here we have -- this needs to be put into context.

There were only three instances where the evidence in this case pointed to benefit expense consideration: TMS, which is not at issue; ABA, which is not at issue; and ASAM.

ASAM, the evidence, at least from the standpoint of UBH, is that both the UBH guidelines and ASAM were consistent with

generally accepted standards of care.

So this was not to move to a new set of criteria that was consistent --

THE COURT: Well, that's not what he said. That's not what Shulman said. It's not even close to what Shulman said.

MR. RUTHERFORD: It may not have --

THE COURT: Shulman had 50,000 changes to them. Maybe not as many as the plaintiff would have liked, but a lot of changes. There was a big red line -- a blue-line document which had lots of changes; and he said that it was inconsistent with ASAM because you don't do this and you don't do this and you don't do this.

Fine. It's not -- it's not just we're adopting something that is, oh, we're obviously compliant, and they're obviously compliant, so it doesn't matter because we're consistent with ASAM. That's not what he said.

MR. RUTHERFORD: That's not what he said, but that's what our people said, Your Honor.

And there may be a disagreement in the evidence, but the UBH clinicians each testified that it was their understanding that the ASAM Criteria was consistent with generally accepted standards of care, and that the UBH criteria was consistent with generally accepted standards of care.

They may have differed, but they didn't differ, at least in terms of the testimony of any of the witnesses that UBH

presented, such that one was consistent with generally accepted standards and one wasn't.

THE COURT: Okay.

What else have you got?

MR. RUTHERFORD: I think that the -- we're going to focus in a moment -- and certainly plaintiffs did in their closing argument -- on a number of flaws in the guidelines, purported flaws in the guidelines; none of which was connected to any testimony of benefit expense; none of which -- no changes of which were subjected to any of -- any such financial analysis.

With respect to the emails, with respect to the testimony, with respect, you know, to the documents that we read, nothing about "acute" being tied to benefit expense. Nothing about "why now" being tied to benefit expense, or custodial or active treatment or child and adolescent care.

And we would submit, given this, given that those financial considerations were not tied to any of the actual guideline issues -- I mean, guidelines at issue in this case, that standard of review should be abuse of discretion without much, if any, scepticism being applied.

THE COURT: Got it.

MR. RUTHERFORD: Which brings us to the guidelines.

The Court's next question was: Did the guidelines at issue contain restrictions that would not allow treatment

that's within generally accepted standards of care?

And we'll start with the coverage determination guidelines.

May I get another water, Your Honor?

THE COURT: Yeah.

MR. RUTHERFORD: Now, other than the custodial care guidelines, which I'll talk about in a second, which were discussed at length in this trial, plaintiffs challenge 209 different coverage determination guidelines that were admitted into evidence on the first day of trial.

And on that same day, plaintiffs introduced Exhibit 880, which was discussed a little bit earlier, which is a stipulation that included a chart of each of the 209 coverage determination guidelines that categorize how, if at all, each of these coverage determination guidelines reference one or more Level of Care Guidelines.

And I think for purposes of the Court's questions earlier, I will refer to a couple of the columns in Exhibit 880.

THE COURT: Just remind me what they mean when you go through.

MR. RUTHERFORD: Yes, Your Honor. So I should have it in -- let me just get my binder.

THE COURT: Yeah.

MR. RUTHERFORD: Set forth in the declaration that is, just for the record, a declaration that is included in -- or

it's a stipulation that's included in 880. The lettered paragraphs on page 8, at Trial Exhibit 880-0009, contain the various definitions of the cross-references between the Coverage Determination Guidelines and the Level of Care Guidelines.

Now, Exhibit 880 reflects that only 81 of the 209 coverage determination guidelines contain language from the Level of Care Guidelines. And that would be in columns F and G.

THE COURT: That's where they reproduce the language.

MR. RUTHERFORD: Yes, Your Honor.

THE COURT: F and G.

MR. RUTHERFORD: In some fashion.

I think the descriptions are, F contains language that is similar to the common criteria and/or language relating to various levels of care from a specific level of care guideline.

And then column G contains all of the provisions of the common criteria and the clinical best practices for all levels of care from the 2015 and 2016 Level of Care Guidelines.

And, by our count, that's 81 of the 209.

THE COURT: Okay.

MR. RUTHERFORD: Sorry.

And Exhibit 880 then reflects that the level of care language is not included -- so the inverse -- in the other 128 noncustodial care coverage determination guidelines.

So there's the custodial care coverage determination

guidelines, the 81 that include either language -- full language or language similar, and then 128 noncustodial care coverage determination guidelines.

And on this the Court heard no evidence, no testimony about what they include, about what they mean, whether they incorporate the terms of the Level of Care Guidelines. Nothing.

THE COURT: Well, other than the stipulation.

MR. RUTHERFORD: Other than the stipulation, correct, Your Honor.

And in response -- we raised this issue, in essence, with Dr. Triana. And Dr. Triana offered the testimony that the only instance in which a peer reviewer is permitted to apply the criteria from a level of care guideline in the decision using its CDG is when that language appears verbatim in the CDG. That's the testimony.

So this idea that the reviewer can click a hyperlink is not supported by the testimony in this trial, which was uncontroverted.

Now, the coverage determination guidelines, the witnesses did discuss, are the seven custodial care guidelines, and some of which we have spoken about earlier.

I think that we covered most of the discussion of custodial and active treatment in the Court's questions earlier. So if the Court is okay with it, I'm just going to

move ahead.

THE COURT: Okay.

MR. RUTHERFORD: So I'm going to move ahead to the Level of Care Guidelines.

These are the guidelines we did hear most about during this trial. There were eight different versions of these guidelines, used from 2011 to 2017. And all eight of them are admitted into evidence.

Plaintiffs' experts provided critiques of multiple portions of these guidelines for each year, critiquing largely the common criteria, the special guidelines for substance use disorders, the three levels being residential, intensive outpatient, and outpatient. And then the specific guidelines for mental health placement. And, again, three specific levels being residential, intensive outpatient, and outpatient.

And Dr. Fishman and Dr. Plakun critiqued language -- critiqued that the language changed substantially over the years. They pointed out some language they liked. They opined that some sections were made more or less consistent with generally accepted standards of care over the years. And, as pointed out earlier, they didn't always agree with each other's critique.

The question for the Court, we would submit, is whether UBH abused its discretion in drafting and using these provisions in each of the levels of care in each of the years.

Now, I'm not going to focus on all of these issues because we're going to be briefing them at post trial. But I do want to point out a few -- a few basic principles that -- that each of the issues that are raised by plaintiffs, at least in some way, touch on this bedrock principle of behavioral health treatment that plaintiffs -- I mean, that -- I'm sorry, patients should be treated in the least restrictive level of care that's effective for their condition, and transitioned into a less restrictive setting if they can be effectively treated and it's safe to do so.

And the external sources, like the APA and ASAM and CMS and LOCUS, and the others that have been mentioned over the last three weeks, all seem to agree that that is an essential and acceptable principle of behavioral healthcare.

And is -- oh, and then consistent with this fundamental principle, UBH's Level of Care Guidelines provide for patients to be treated in the least restrictive appropriate level of care in which they can be treated effectively, efficiently, and safely.

What the plaintiffs challenged and what was mentioned in Mr. Goelman's closing argument is how UBH's guidelines reflect this concept.

Dr. Fishman and Dr. Plakun testified that the guidelines overemphasize acute changes, or the "why now" factors, at the expense of chronic conditions when evaluating whether treatment

could be effectively, efficiently, or safely provided in the less intensive level of care.

First, in the 2011-2013 guidelines -- let me say, this gets raised in a different way over what I think of as sort of three blocks of the guidelines.

First, in the 2011-2013 guidelines, the Level of Care Guidelines reference the patient's current condition or presenting problems. And plaintiffs' expert testified that they are concerned that this might lead reviewers to place too much emphasis on a member's immediate condition and ignore any potential chronic conditions or complications.

Then in 2014 to 2016, plaintiffs' experts shift their focus to the "why now" language, again saying they are concerned reviewers would read this to mean that only acute crises are covered.

And then, finally, in 2017, when the "why now" phrase is removed, plaintiffs' experts testified that they continue to be concerned that references to, quote, factors leading to admission, or, quote, factors that precipitated admission, are overly narrow and might foreclose paths to treatment -- or pathways to treatment for certain types of members, such as members suffering from chronic conditions.

So let's look at the rest of the evidence.

The 2011-2012 language focused on the member's current condition or presenting problem. UBH's doctors, including

Dr. Martorana and Dr. Allchin, as well as UBH's expert, Dr. Simpatico, testified that, quote, presenting problems, closed quote, include assessing all of the patient's current conditions, including chronic conditions, in the context of the particular symptoms that led the patient to treatment at a particular level of care.

These doctors explained that information that is gathered and used to access presenting problems is the information detailed in the best practices section of the guideline -- the guidelines, I'm sorry -- which include chronic conditions, co-occurring behavioral and medical conditions, treatment history, and many other factors.

And they testified, patient placement is about fit; finding the right level of care for safe, effective, and minimally restrictive treatment that match the member's current needs.

Now, for 2013, we first see the "why now" language.

THE COURT: 2014, you mean?

MR. RUTHERFORD: No, 2013. That's the year it appears once, Your Honor, in paragraph 3a.

And that's when we first see the "why now" language. It's included in the section requiring that a provider collect information from the member and, when appropriate, other sources to complete an initial evaluation of the member's chief complaint/presenting problem, and the events which precipitated

the request for service at this particular point in time; i.e., the "why now."

Neither of plaintiffs' experts criticize the "why now" language in 2013, and both agree that it's important, without more, to evaluate and consider "why now."

In fact, Dr. Fishman testified that he didn't think that even the way that it is phrased as "why now," that those things -- he said, "And I do think that even the way that it is phrased as 'why now' those things ought to be considered. It's a useful clinical tool."

And this is consistent with what Dr. Bonfield, UBH's chief medical officer in 2013, testified about "why now."

Now, Dr. Bonfield is a psychiatrist with more than 45 years of training and experience. He testified that adding "why now" was his idea. He explained that "why now" is the way to understand why a person is presenting now for treatment and what is the root cause.

Dr. Martorana also testified that considering the "why now" does not exclude consideration of chronic conditions, and has a consumer-centric whole-person focus.

Now, in 2014 to 2016, which the Court just mentioned, the "why now" factors were integrated throughout the common criteria and throughout the separate level of care criteria.

And plaintiffs' experts focus on the references to acute changes in the member's signs and symptoms, asserting that the

"why now" factors in 2014 to 2016 exclude chronic conditions.

But UBH's doctors who use the guidelines testified that that's not the case. Dr. Martorana testified that acute changes have to do with recent and significant differences in the patient's condition, and the psychosocial and environmental factors that relate to where the person lives, and whether they can support themselves in their relationships and family and education, and that this provision does not exclude consideration of chronic conditions.

Dr. Alam testified that when you talk about acute symptoms, you're really referring to the acute changes of a chronic condition. Most of what we treat now, whether it's substance use disorders or mental health conditions, they are chronic conditions.

Now, finally, in 2017, UBH removed the "why now" and "acute" language from the common criteria and from the outpatient and intensive outpatient criteria. So it only remained in the residential treatment criteria, Your Honor, for 2017, resulting in criteria, with respect to admission, that provided that the member's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care, assessment and/or treatment of the factors leading to admission require the intensity of services provided in the proposed level of care. Yet plaintiffs still challenge this language.

For example, Dr. Fishman claims that even though the word "acute" isn't used in this context, the phrase "factors leading to admission" may still focus the user to think about acuity.

There was no evidence that UBH reviewers read this provision as focusing on acuity. Dr. Martorana testified that "current condition" includes chronic conditions. Chronic conditions can impact current symptoms.

THE COURT: Everybody has testified, from the UBH side, that the taking out of the "why now" concept from these various provisions did not change the guidelines. Didn't change the guidelines; right? Didn't change the Level of Care Guidelines.

MR. RUTHERFORD: Right.

THE COURT: That you still were focusing on the same things you were focusing on when it said "why now."

MR. RUTHERFORD: True. But part of what the Court is doing is also analyzing the words and taking into consideration the critique of the plaintiffs' experts. And so I felt obligated to raise that issue.

THE COURT: No, that's okay.

MR. RUTHERFORD: Now, the "acute" does appear in 2017, in connection, as I said, with the 24-hour levels of care. That's residential treatment and inpatient treatment.

But we would submit that that focus is supported by the CMS Benefit Policy Manual and Guidelines, which we would draw

the Court's attention to at Trial Exhibit 656 and Trial Exhibit 1507.

Taking all of this together it, what is the evidence about "acute" and "why now" in the Level of Care Guidelines? That the "why now" language and the use of the term "acute changes" was not in the 2011 or 2012 Level of Care Guidelines; that in 2013 "why now" was added, and plaintiffs have no critique of that addition.

But in 2014, the guidelines include the terms "acute changes" in "why now," and that there aren't any significant changes through 2016. And that both terms were taken out -- except for what I mentioned -- in 2017.

Furthermore, as Dr. Martorana explained, "why now" is consistent, in his view, with generally accepted standards of care. The language is included to address, as Dr. Bonfield said, the root cause for why patients would come to treatment with a consumer-centered focus.

And it includes consideration of all of the factors that give rise to treatment, including acute, chronic symptoms, and all of the family and psychosocial factors that we see in a typical evaluation.

Now, the second of the LOCs that I want to focus on, which was discussed at length during plaintiffs' closing argument, is improvement.

There were three iterations of the improvement language

during the class period. Plaintiffs' primarily critique UBH's improvement criteria for including the term "acute" and for stating that "improvement should occur in a reasonable period of time."

Now, UBH agrees that the definitions of "improvement" don't track CMS exactly; and, yes, the language was modified and other language was not included.

But, as Dr. Martorana testified, who used these guidelines, "improvement" in the Level of Care Guidelines doesn't mean that there is no more coverage once the presenting symptoms improve. It means that reduction and control of acute symptoms, as the guideline states, get weighed against evidence that the member might deteriorate if treatment in the current level of care ends.

He testified that weighing of the risk of deterioration and concern for recovery and resiliency equates to maintenance of the member's condition.

And with respect to "a reasonable period of time," Dr. Fishman's concern is that it directs the user to the notion that a clock is ticking and that this was not -- but this wasn't borne out by the doctors who used the guidelines. None of the doctors testified that "a reasonable period of time" was equated to the notion of a clock ticking.

In fact, Dr. Martorana testified that the "reasonable period of time" in this provision is individualized, based upon

clinical judgment, and is not a specific set period of time.

I'm just going to skip ahead, Your Honor.

That while not necessarily addressed in the Court's questions from the pretrial order, I do want to just address these state mandate claims for a moment, Your Honor.

THE COURT: Uh-huh.

MR. RUTHERFORD: Now, plaintiffs bear the burden of proving their claims with respect to each stated issue in this case. That means that for each of the four states -- Texas, Illinois, Connecticut, and Rhode Island -- plaintiffs must prove that UBH was obligated to use a particular set -- a particular and mandated set of guidelines in lieu of UBH's internal guidelines; and that UBH did not, in fact, use the mandated guidelines.

And each of these states presents a somewhat different legal or evidentiary issue, so I'm going to go through them briefly in turn.

Let's take Texas first. The only evidence that plaintiffs offered to prove that UBH failed to use the Texas Department of Insurance guidelines for Texas-based treatment during the class period was the email that we saw about potential confusion in the Houston Care Advocacy Center about the use of coverage determination guidelines and nonmedical necessity determinations.

Now, I don't have the quote from Mr. Goelman in front of

me, so I'm not saying that I quote this accurately, but what the coverage area is, and what the role is of the Houston Care Advocacy Center, is not in evidence in this case. That was not in evidence.

What is in evidence in this case is the testimony --

THE COURT: So you're saying I can infer that the Houston Care Advocacy Center included, among other things, since they're talking about the Texas guidelines, things that are covered by the Texas guidelines?

MR. RUTHERFORD: I think the way it works -- and, again, I'm not sure this is in the evidence -- what determines the state -- what determines the state that covers the plan depends upon where the plan is based and the situs -- sometimes. And other times the situs of the actual treatment. So it differs.

THE COURT: Can't you absolutely infer from that email that the Houston Care Advocacy Center was sometimes doing business/making determinations that it thought were the kinds of business that if you had to apply the Texas guidelines, you would apply them, because that's why they asked the question. They said, We're not using it.

So isn't it a complete and fair inference that, yes, that shows that for some -- I don't know how many -- for some, they weren't applying the Texas guidelines? How could you dispute that inference?

MR. RUTHERFORD: I think that's two different questions.

So the first inference is, can we draw the inference that the people in the email were involved in applying the Texas guidelines? Yes.

THE COURT: Yes.

MR. RUTHERFORD: I dispute the inference that the -- that they were failing to do so. Nobody within that email was testifying about it.

THE COURT: That's what they said in the email. It's in evidence.

MR. RUTHERFORD: Agreed, Your Honor.

THE COURT: The Houston Care Advocacy Center was not applying --

MR. RUTHERFORD: Let me point out what else was in the evidence, Your Honor.

THE COURT: But --

MR. RUTHERFORD: I understand that, Your Honor.

THE COURT: I understand there's testimony. There's testimony from -- and I can't remember who was on the stand and said, we've been applying it since 2003, or something like that. I appreciate that.

Doesn't this evidence also say that they weren't applying it?

MR. RUTHERFORD: Yes, this evidence says that they

weren't applying it.

And the evidence that says that they were is the testimony of Dr. Martorana, the testimony of Dr. Allchin, the testimony of Mr. Niewenhous, and the guideline applicability tools, one of which is at Exhibit 268, that states, in the Guideline Applicability Tool, that UBH uses the mandated Texas guidelines.

And they are specific guidelines, Your Honor, that are mandated. This is not one of the states where you can use, essentially, a corollary guideline.

That is the case with Rhode Island. So with respect to Rhode Island, the question is whether or not the relevant statute requires the use of ASAM.

And the statute in Rhode Island provides, the payor shall rely upon criteria of the American Society of Addiction Medicine when developing coverage for levels of care for substance use disorder treatment.

And the evidence shows that UBH did rely on the ASAM Criteria when creating and revising its internal guidelines, which it used for Rhode Island.

With respect to Connecticut, Connecticut gives -- essentially provides two ways to comply. You can either use ASAM or you can use internal guidelines and then post a cross walk showing the differences between ASAM and the guidelines.

And Mr. Niewenhous testified about UBH's compliance with

this requirement. The Court is obviously aware of the testimony, including UBH's communications with Connecticut insurance regulators about it.

And while he did note one mistake in the document, that he said he recently noticed, his testimony otherwise did not reflect any intent to represent any fact with respect to UBH's compliance with Connecticut law.

Finally, there is the state of Illinois. So with respect to the state of Illinois, before September 2015, the evidence shows that state law provided that medical necessity determinations for substance use disorders shall be made in accordance with the ASAM criteria.

And then in September of 2015, Illinois law was amended to state that no additional criteria may be used to make medical necessity determinations for substance use disorders.

The evidence shows that UBH considered the pre September 2015 law and whether its guidelines were in accordance with ASAM, and concluded that they were. And that's at Exhibit 353.

And Dr. Martorana testified that after the second law was passed, by no later than January 2016, UBH had adopted use of ASAM in Illinois and currently uses it today.

Now, the last of the Court's remaining questions was: Did UBH abuse its discretion as a plan administrator in promulgating the guidelines or using the guidelines in connection with the claims it denied?

And after considering all the evidence, we submit to the Court that the answer is no, it did not abuse its discretion.

As Dr. Triana and Ms. Urban testified -- and she was the one who testified, Your Honor, by video -- UBH employed a year-round review of recognized sources in connection with updating and amending the guidelines.

This review included some of the same sources upon which plaintiffs rely, and ones I have mentioned earlier today, including CMS, APA Practice Guidelines, and ASAM.

That each year UBH sought and received input about its Level of Care Guidelines from internal and external behavioral health experts, and through its internal process alone, UBH sought and received input from dozens of in-house psychiatrists, doctorate level and masters level behavioral specialists.

And we have at Exhibit 1235 a sample list from 2016.

Each year UBH sent out letters by mail and email, asking for feedback. The four questions that were asked, which were pointed out by plaintiffs in their examination of Dr. Triana, were whether the guidelines -- whether the guidelines offer adequate support for making decisions about care; whether the guidelines were organized in a manner that makes them easy to use; whether the criteria are ambiguous or unclear; and whether there are criteria that should be added or deleted.

The criticism was, these solicitation letters didn't

include a fifth sentence that said, Are the guidelines consistent with generally accepted standards of care?

But, as Dr. Triana testified, he expected that the person or persons providing feedback would make any recommendations to UBH about whether any language was inconsistent with generally accepted standards of care based upon the questions that were asked.

And these requests for feedback went out to dozens of external behavioral health providers annually. They included representatives of several subspeciality organizations that were part of this BSAC, that the Court heard testimony about.

And Dr. Triana testified that each year this internal and external feedback was gathered and organized into charts and summarized.

And the Court has feedback from each -- maybe not each of the years, but I think for most of the years in question in evidence.

This feedback was then discussed by a Level of Care Guideline Workgroup which included clinicians such as Dr. Robinson-Beale and Dr. Bonfield.

Through this process, over the entire class period UBH received scores of comments about its guidelines.

Now, regardless of whether this feedback was critical or neutral or complementary -- and when the Court reviews these feedback, I think the Court is going to see all three types of

feedback -- UBH's level of care guideline reviewed and considered it.

Now, after the guideline -- Level of Care Guideline Workgroup reviewed, the BPAC would meet. It would meet at least once a year, and it would vote on the updated guidelines. And the Court has each of those BPAC minutes in evidence, except for, I think, 2015.

Now, was this process a process that was a standard accredited by an external agency?

Well, as Dr. Goddard, an expert in healthcare accreditation, and as Mr. Beaty, a UBH employee, testified, this satisfied and even exceeded the nationally recognized standards of two primary organizations that are used to accredit healthcare utilization management companies. And that's URAC and the NCQA.

In particular, Dr. Goddard opined that UBH could have satisfied URAC's and NCQA's requirements by simply seeking internal staff input.

UBH's solicitation of external providers and nationally known psychiatric associations surpassed accreditation standards. And beyond this -- passed accreditation standards.

So, in sum, UBH's annual work to obtain external feedback from experts from across the spectrum in behavioral health demonstrated that not only did UBH act in good faith in its development and updating of its clinical criteria, but also the

healthy debate among experts about whether the guidelines are consistent with generally accepted standards of care.

Now, the task before the Court is to determine whether UBH abused its discretion by promulgating and applying the guidelines at issue in this case.

We would submit that the question isn't whether the guidelines were perfect. And we don't contend that they were. That's why every year UBH seeks advice from doctors, inside and outside of UBH, to adapt and improve the guidelines, to try to make them better.

But a fiduciary, Your Honor, doesn't need to get it 100 percent right 100 percent of the time.

The evidence shows -- I'm sorry, the question of whether the good-faith efforts of dozens of UBH doctors, psychologists, and social workers, reflected in each of the guidelines at issue in this case, were so far afield from what the plans required that they were illogical, implausible, or completely unsupported by the evidence, and the evidence shows that they were not.

The Court heard conflicting testimony about the guidelines. Plaintiffs experts, Drs. Fishman and Plakun, opined that the guidelines overemphasized certain things and underemphasized others.

UBH's expert, Dr. Simpatico, and several of UBH's psychiatrists, opined that the guidelines were fully consistent

with generally accepted standards of care.

And these disagreements about the guidelines are consistent with the other evidence we saw in this case; namely, in form of the feedback that really ran the gamut. It's a mix. Some of it positive; some of it critical; some of it fairly neutral.

We submit that's precisely the point. If reasonable minds, clinicians from across the spectrum, all trying to do their best for patients and members, can honestly disagree about UBH's guidelines, then UBH's guidelines cannot constitute an abuse of discretion.

Thank you, Your Honor.

THE COURT: Thank you, sir.

Anything further?

MR. RUTHERFORD: Not from me, Your Honor.

MR. GOELMAN: Your Honor, can we have a short break?

THE COURT: No.

MR. GOELMAN: Is it okay if Mr. Cowart handles our rebuttal?

THE COURT: Yeah. I don't know what else there is to say. So be brief.

MR. COWART: Less than five minutes.

THE COURT: Go ahead.

CLOSING ARGUMENT

MR. COWART: Your Honor, my name is Jason Cowart.

THE COURT: Oh, good to meet you.

MR. COWART: You may recall, four years ago I argued the motion to dismiss in this case.

THE COURT: Yes.

MR. COWART: I think I want to make three points. Two of them legal; one of them factual.

The first is a legal point having to do with the Court's questions concerning how ERISA analyzes conflicts of interest.

As the Court is no doubt aware, most of the conflict of interest case law develops in the context of a single individual bringing a claim under their plan. And the question is whether the administrator has properly interpreted that plan. There are not very many cases that analyze guidelines in the context of that. So this is relatively new in that respect.

So usually the question is: Did the administrator interpret the plan terms in a self-interested way? So the guidelines make this somewhat novel. But our theory is as follows:

Generally accepted standards -- there are only one set of generally accepted standards, whatever they are.

United Behavioral Health had an interest in narrowly interpreting that phrase, those standards, because a significant portion of its business relates to fully insured products. So it had a financial self-interest in narrowing

what it considered to be generally accepted standards.

But because all of the plans that it administers require, as one condition of coverage, that the care be consistent with generally accepted standards, it had to also use those same guidelines vis-a-vis self-funded plans.

That's exactly what it did. And if it had done something differently, everyone would have asked, Why? How is it possible that generally accepted standards are different on the self-funded side than they are on the fully insured side?

And so our position is that that self-interest, that was alive and well and actually meant dollars in the pockets for UBH on the fully insured side, infected its decision-making on the self-funded side, despite the fact that on the self-funded side it was not personally paying the benefits.

That's the theory.

THE COURT: Okay.

MR. COWART: And I believe that the evidence supports that theory. Okay. That was the first legal point.

The second has to do with the question of whether United Behavioral Health, whether it's appropriate for UBH to worry about ben-ex. Is that appropriate? Can they talk about it? Can they talk about it with plan sponsors? And the answer is yes, they can.

When they go out to a self-funded plan, an employer, and they're talking about designing the plan, it's entirely

appropriate for them to project for the plan how much they think they'll have to pay. And it's entirely appropriate when UHIC sets premiums for its fully insured plans, it's entirely for UHIC to make certain estimates about how much it thinks it's going to pay.

But something fundamentally important happens the minute that UBH begins to administer benefits, because suddenly all of the ERISA fiduciary duties come down and a wall is supposed to exist around that administrator. And that administrator, once they started administering benefits, is supposed to ignore all of those conversations of ben-ex.

Which is precisely why the case law has developed to say that people who make benefit decisions owe two kinds of duties: A duty of fidelity to the plan terms as written and reasonably interpreted, and the interests of the beneficiaries.

And so while it's appropriate -- we don't dispute that UBH, as a, quote-unquote, managed care company, can worry about all these things and talk about all these things and worry about fraud and worry about ben-ex and worry about all kinds of other things.

When Congress enacted ERISA, it did something knowing it, which is it said you can do all of that, but the minute you started administering benefits, which are viewed in ERISA as a trust, you take on those common law trust obligations: fidelity to plan terms, interests of beneficiaries. And ben-ex expense

is explicitly not one of the things that an ERISA fiduciary is allowed to consider.

The statute couldn't be more clear about that. That's the second legal point.

The third point is the factual one. There's been a lot of discussion in this cases about all these guidelines. And we're going to give you briefing which is going to lay out chapter and verse year to year, provision to provision.

I want to just make sure that we are very clear about what our, sort of, meta position is, if you will. And here it is:

In 2011 and 2012, the guidelines were focused on "presenting signs and symptoms." In 2013 through '16, the words that were used were the "why now" factors. And in 2017, UBH reverted back to "presenting signs and symptoms."

Our position is that "presenting signs and symptoms" or "why now," what that means is has there been an acute change in the member's symptoms that necessitate some kind of new treatment.

So, for example, a chronic alcoholic, where nothing has happened, they have simply been a chronic functional alcoholic for 30 years, and they go in for treatment one day because they decide that, today is the day I'm finally going to address this problem, there has been no change in their symptoms. There's been no acute change when the question gets asked, What is the acute change? Why now? And the answer is, I don't know why

now; nothing happened.

Under UBH's guidelines as written, that person doesn't get coverage. And that was true --

MR. RUTHERFORD: Your Honor, I don't think this is based upon the testimony in the case.

THE COURT: Overruled. There actually was direct testimony on this almost exact point.

So go ahead.

MR. COWART: That was true in 2011, and it was always true through the end of 2017.

Now, it is also true that every one of UBH's witnesses took the stand and said that's not what "presenting signs and symptoms" means; that's not what "why now" means.

But when you go back into chambers and you think about the evidence, I'd ask you to think about two things:

One, why is UBH not -- of the hundreds of pages, thousands of pages of documents in this case, numerous exhibits, hundreds of exhibits, there's not a single, not one contemporaneous document that supports what the witnesses told you from the stand. No PowerPoints. No emails. Nothing. Not a single document. All you have is self-serving testimony from the stand.

And, second, when you think about that testimony, I'd ask you to compare the best practices provision and the detail with which that provision discusses the myriad of considerations,

chronic and co-morbid and acute, and contrast that with the front side of the coverage guideline -- level of care guideline and the myopic focus on presenting symptom changes or "why now" factors.

And I would submit to you that that evidence, in total, suggests that not only do the guidelines represent a departure from GASC, as written, but that the evidence is overwhelming that in practice that's exactly what they did.

Thank you, Your Honor.

THE COURT: Fine.

Okay. Ladies and gentlemen, thank you so much.

What shall we do now?

(Laughter)

THE COURT: What did you have in mind?

MS. REYNOLDS: Your Honor, the parties, unfortunately, have not reached an agreement on this issue.

Yesterday, counsel for UBH announced an intention to file a motion to decertify, which was the first time that plaintiffs were made aware of this.

We did ask the grounds for this last night, and we were told it turns on a failure to present class-wide proof as to all guidelines, all plans, and all years.

We find that, frankly, somewhat outrageous. We just completed a trial in this case in which no individualized proof at all was offered --

THE COURT: Leaving that one aside. And I'll decide when I'll allow it. The whether is not true. I will allow it at some point.

Have you agreed on the briefing for everything else?

MS. REYNOLDS: Well, no. The issue is that UBH wants to do two tracks of briefing at the same time.

THE COURT: No, we're not doing them at the same time. That's not happening.

MS. REYNOLDS: All right. So plaintiffs --

THE COURT: I know what the arguments are. I actually ruled on the arguments before.

I'm going to allow you, for purposes of whatever you want, to make a motion at some point. But we're going to brief this thing first.

So what do you want to do about -- they wanted two tracks; you wanted one track. Do you have a track line for any of these tracks?

MS. REYNOLDS: The proposal that the plaintiffs made was that plaintiffs' brief and the associated chart that the Court required would be due on December 6th, which is five weeks from today; that UBH's brief would be due on January 10th, five weeks after plaintiffs' brief; and that plaintiffs' reply will be due January 31st.

THE COURT: And what was UBH's proposal?

MS. ROSS: Well, Your Honor, our proposal, which, as

Ms. Reynolds has said, would have also included a simultaneous briefing on the motion for class decertification, which we are fine to defer; although, we note that under Rule 23(c)(1)(C) that would need to be addressed before final judgment is entered in the case.

THE COURT: Oh, we're quite a ways from final --

(Laughter)

MS. ROSS: With respect to the briefing schedule --

THE COURT: I think I can make that.

MS. ROSS: Think we can squeeze it in.

THE COURT: I'm still a judge. I can make that.

MS. ROSS: Understand.

With respect to the briefing schedule, only two points we would raise that differ from the plaintiffs' proposal. The first is a relatively modest change in the timing, simply to add five days to each of the initial briefs. Which would put us at December 11th for plaintiffs' proposed trial brief and the chart that the Court has requested. And then at January 22nd for UBH's brief. And that's in part to account for the intervening holidays.

And then with respect to the reply brief, it is not our understanding, at least at this point, of the Court's prior comments that the plaintiffs would have a reply brief.

We assumed this would be proposed findings of fact and conclusions of law, along with the chart that Your Honor has

requested. Although, obviously, we'll defer to the Court on that.

THE COURT: We'll have a reply brief.

So if I have a December 11th opening brief from the plaintiff, responding brief from the defendants on January 22nd, when do you want to have your reply brief?

MS. REYNOLDS: If we can have three weeks, Your Honor, that would be --

THE COURT: What did you have? You had three weeks --

MS. REYNOLDS: We had --

THE COURT: Just tell me what the date is.

MS. ROSS: February 12th. And that's fine with us.

THE COURT: Okay. So that's reply, opposition.

So I don't envision this just being the -- you'll do proposed findings of fact and conclusions of law with pin cites to testimony and cites to exhibits, and all that stuff. But I envision an actual brief that makes your case on either side, and attaches to that brief the chart that really walks through each of the provisions and why it's bad, and where the evidence is that shows it's bad, or good, or not bad or not abuse of discretion. I don't mean to prejudge that.

But I do think -- I don't -- but I do think it's useful to do this in a narrative form. Findings of fact and conclusions of law are great because it puts forward the detail of the exact thing that you think I need to find and cites to where

the evidence is. And I can take that and I can use it or not use it. But the brief is narrative and presents them in an argument form.

And I want them in an argument form. So I'm talking about both for briefs and proposed findings of fact and conclusions of law. And then I'll look at it and I'll decide whether I need to see you again.

I should tell you, this is going to take a while. It's going to take a while for you to do what you're doing. It's going to take -- you know, there's six or eight per side writing these things. There's two of us working on this. So it's going to take a while.

So I don't know how long "a while" is. You can always call Judge Ryu if you get tired of waiting.

But, okay. That's fine. So that will be the schedule. Those will be the briefs.

Is there anything?

MS. REYNOLDS: Not for --

THE COURT: He's always got something.

MS. REYNOLDS: Our detail man.

MR. ABELSON: On the subject of the transcript depositions, I think our understanding is that they should be attached as exhibits.

So I would just like to formally move into evidence Exhibits 903 and 904, which are the transcripts of the

depositions of Ms. Bridge and Mr. Rockswold.

THE COURT: Okay.

(Trial Exhibits 903 and 904 received in evidence.)

THE COURT: And your motion is granted as well.

MS. ROSS: Thank you, Your Honor. We have no objection.

THE COURT: UBH's motion is granted to put in their transcripts.

MR. ABELSON: Thank you.

And with respect Exhibit 880, which is the stipulation with respect to the guidelines, the parties have a version to replace, that replaces the Bates number with the trial exhibit numbers, for your convenience. We'll replace that in the record.

THE COURT: I always appreciate it when people take care of my convenience.

(Laughter)

THE COURT: So let me just say, a remarkable experience. It was great. And you were all terrific and patient with my trying to get through this, and patient with my way of getting through it, and patient with my impatience most importantly. But I really appreciated all the work you did.

And if you will stay for a second, I would like to shake your hands. So we will be adjourned.

(Proceedings concluded 1:13 p.m.)

CERTIFICATE OF REPORTERS

We certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

DATE: Wednesday, November 1, 2017

Katherine Powell Sullivan, CSR #5812, RMR, CRR
U.S. Court Reporter

Jo Ann Bryce, CSR #3321, RMR, CRR
U.S. Court Reporter